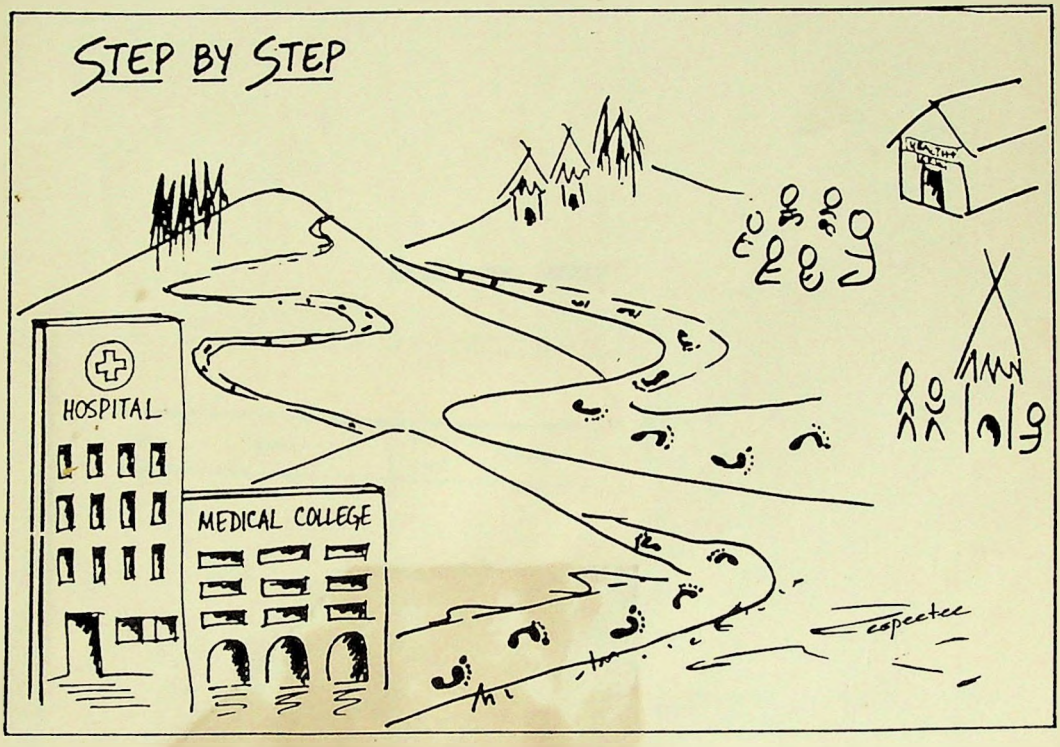

(A C.H.C. - C.M.A.I. - C.H.A.I. PROJECT 1990-92)

Research Project : Strategies for Social Relevance and Community Orientation in Medical Education : Building on the Indian Experience

STEP BY STEP

Community Health Cell, Bangalore*

June 1992

Sponsored by : Christian Medical Association of India (CMAI), Catholic Hospital Association of India (CHAI), Christian Medical College, Ludhiana (CMC-L).

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INTRODUCTION

The challenge of reorienting Medical Education to meet the health needs of our people in the diverse socio-cultural-political-economic realities of our country has been an area of interest of both the researchers from the time of their graduation from St.John's Medical College, Bangalore in 1972 and 1978 respectively. This interest was particularly stimulated by internship experiences in a Bangladesh refugee camp (1971), and a Andhra cyclone Disaster Relief Camp (1977). The experience of the practice of primary medical care in conditions of mass poverty and disaster-linked health situation, led to a process of reflection on the relevance of the large, high-technology, teaching hospital focus of medical education in preparing doctors for the challenges of community health. This interest led to various reflections, and initiatives related to medical education over the past two decades, which have been brought together in this separate anthology of articles and reports (See Table). It was this varied experience that led the researchers to evolve the "Medical Education Project" entitled Strategies for Education - Building on the Indian Experience, which the CHC has facilitated since April 1990.

An edited compilation of the key articles, which formed the background to the project, was therefore seen as a logical first step as well as a component of the project output.

- STEP BY STEP -

Towards An Appropriate Medical Education

The CHC/CMAI/CHAI/CMC-L Project on `Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian Experience' was based on a long involvement of the primary researchers in exploring how medical education could be made more relevant to the needs of society. These included many initiatives before the formation of CHC, followed by some during CHC's formative years.

This report therefore brings together the key initiatives/reflections of the researchers which preceded the study and helped to give the project greater focus.

CONTENT LIST

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A. TOWARDS AN APPROPRIATE MEDICAL EDUCATION

Step by Step

1. In 1971 RN worked in a Bangladesh refugee camp in Neelganj, near Calcutta, for three months as part of the public health posting in his compulsory rotating internship. This experience began a process of serious reflection on medical education which led to a student/intern's reflection on Making Medical Education relevant to the needs of Society - a paper presented at the first students seminar organised by the Indian Association for the Advancement of Medical Education at its annual Conference at the Armed Forces Medical College, Pune in February 1972 (Article B). The paper made a plea for the widening of a medical student's horizon from a severely clinical-patient oriented outlook to a wider socially conscious - community outlook. The paper was published in the Indian Journal of Medical Education as well as in the Indian Journal of Preventive and Social Medicine. It was later quoted by the Parks textbook of Preventive and Social Medicine (now Community Medicine) in the chapter on `Concepts in Community Health' in the section on `Barriers to Health Services'.

   "Shortcomings in medical education : The system of medical education may itself be a barrier to health services if the medical education is not oriented to the needs of the community. This is a subject of great criticism in India . The' shortcomings of medical education are stated as follows:

   a) It is not structured to meet the health needs of the community.

   b) It is not community oriented.

   c) because it is hospital oriented, too great emphasis is laid on specialisation.

   Consequently the young doctor is not emotionally prepared to face his new role in the community".

2. In June 1973. RN submitted a dissertation to the London University for the Diploma in Tropical Public Health on the theme of Trends in Undergraduate Medical Education in India : Training doctors for Community Health Services.

   This dissertation was an overview of 25 years of post-independence development in Medical Education in India. It covered areas such as the History of medical education; growth and development of medical education since independence; the challenge of medical care in rural India; reorientation of Medical Education for Community Health Services; incentives for Rural work; Medical Education and migration of medical manpower and a discussion on alternative approaches to reform. The dissertation was in response to a proposal being considered by the Government of India (at that time), to evolve a course for doctors that was shorter and less expensive than the existing one.

The dissertation outlined a few principles which could be applied in the planning of a proposed 3 year diploma course. It also made a concerted plea for a continuing process of reorientation of the ongoing M.B.B.S. course (see article C) which included:

i) University involvement in health care;

ii) Improvement of standards of teaching and teachers;

iii) Documentation of local knowledge and needs and development of local technology;

iv) Appreciation of economy and effective utilization of available services and resources;

v) Involvement of general practitioners;

vi) Need for evaluation of introduced changes; and

vii) Motivation of the medical profession.

3. From 1973-1983, both the primary researchers had the opportunity to participate in a process of reorientation of Medical Education at St.John's Medical College, Bangalore which included primarily the development of many rural and urban field practice areas and many efforts to move training beyond the teaching hospital. Two initiatives - Rural Orientation Camps and Rural Community Health Clinic Experience for interns were particularly significant and were reported in the Asian Community Health Action Network newsletter . (See Article E).

4. In 1977, RN had the opportunity to study and reconstruct (through documentation review, field visits and interactive interviews), the Kottayam Experiment as a project during his postgraduate studies at the All India Institute of Medical Sciences, New Delhi. This experiment, relatively unknown, conducted by Prof. Jacob Chandy, Neuro Surgeon and ex Dean of Christian Medical College, Vellore, was a post retirement effort aimed at operationalising a project which he was unable to undertake earlier while working in a `medical college situation' - under the framework of the MCI recommendations. The experiment attempted to train a community oriented health professional in what was India's only experiment, in integrated, community based training.

5. In 1982, both the researchers `dropped out' of faculty positions in the medical college and spent a year travelling to many parts of the country to visit doctors and health workers trained by the college and to experience the challenges and problems they were facing in `health action' at the grassroots. This year of travel and reflection was a very intense `personal' and `dialectic' experience which was documented in a reflection note that was circulated to colleagues and peers in 1983/84 (See Article D).

6. In October 1983, the primary researchers moved beyond their medical college jobs to a study-reflection-action experimental project (Community Health Cell) with voluntary agencies involved in Community Health in South India, particularly Karnataka.

   While medical education was not the main focus of this experimental project there were many occasions and stimulus for involvement in further reflections on reorientation of medical education to meet the challenges of community health in India.

7. i) In October 1983, (RN) wrote a review article entitled "150 years of Medical Education: Rhetoric and Relevance" as a background paper for the medico friend circle annual meeting in Calcutta on Medical Education . This was published in the medico friend circle bulletin in January-February 1984. (Appendix IV)

7. ii) As further background to this meeting, a compilation of the key recommendations of Medical Education by four expert committees appointed by the Government of India were also made. These included the Bhore Committee (1946), the Patel Report (1970), the Srivastava Committee (1975) and the Health for All - an alternative strategy report of the ICSSR/ICMR study group (1981). This was distributed to all those interested in the compilation, on request.

8. In December 1983, as part of the first visit of Dr. Zafarullah Chowdhury (of Gonoshasthya Kendra Project of Bangladesh) to Bangalore, an adhoc meeting on `Medical Education' was organised at St.John's Medical College. At this meeting Dr.Zafarullah had an opportunity to share some of the early thinking of the `alternative medical school' being planned by a group in and for Bangladesh.

9. In January 1984, the Annual Meeting of the medico friend circle considered various aspects of Medical Education reforms, particularly:

   a) Content and structure of pre-clinical, clinical and para-clinical teaching.

   b) Content and structure of community medicine teaching and

   c) Methodology in present system of education.

10. In May 1984, CHC facilitated a workshop organised jointly by St.John's Medical College and Catholic Hospital Association of India for the first twenty pioneers of a Rural Bond (Placement) Scheme organised by the college since 1980. The Workshop gave an opportunity to the participants to reflect on:

    a) Medical Education, and

    b) Challenges and problems of peripheral hospital practice.

The report and recommendations on medical education (See Appendix I) was submitted by a small team (nominated by the workshop participants) to the staff council of the medical college to consider and reflect upon, with a view to introduce changes in the curriculum and methodology of teaching in that college, so that the rural placement scheme would be seen more as a `challenging opportunity' rather than, just an obligation.

11. In the years 1984-86, the CHC also shoulderd the responsiblity of managing the organisational responsiblities of the medico-friend circle, including the convenorship and the editing and publishing of its monthly bulletin. During these years, the proposition to work towards an mfc statement on medical education as well as an anthology on that theme was mooted and accepted as an important and meaningful initiative. Articles and group reports were edited and compiled by an editorial collective. In 1988/89, taking the opportunity of a delay in publishing the anthology, two additional articles were added by CHC to the original collection, to make it more comprehensive and to keep the readers better informed about the evolving situation of medical education reform and innovation in the country.

    a) An article highlighting `Recent initiatives towards the Alternative' brought together information about the National Health and Educational Policies; the JNU plea for a new public health; the ROME experiment; the Kottayam experiment; the Network of Community Oriented Health Science Institutions; the abortive attempts at an alternative track - 1988; the Consortium of medical colleges on Inquiry Driven Strategies; the Miraj Manifesto; the Health University Development; the National Teacher Training Centre; the Epidemiological Networks; the Edinburgh Declaration of 1988; and the perspective plan for the Scientific Advisory Committee. While reviewing all these positive developments, the paper also highlighted the disturbing developments in health care and medical education including, `capitation fees' colleges, privatization; diagnostic technology glorification, the unsolved private practice problem and so on.

    b) The second addition by CHC, probably adding greater significance to mfc's efforts, was the development of a compilation on the lines of the Medical Council of India Curriculum - 1982, of an alternative framework of a curriculum entitled `Anthology of Ideas'. This compilation evolved from various extracts of articles and group discussions in the Anthology.

    The mfc Anthology was published in January 1991 and included both these articles as well as the 150 year review article mentioned earlier (Appendix IV).

12. In 1988 CHC initiated an informal network of community health action initiators in Karnataka, primarily Bangalore based, called the CH-Network. In one of the regular meetings of the network, many of the participants felt that we should make a

representation through a memorandum for the consideration of various relevant options and alternatives by the newly constituted Committee for the University of Health Sciences in Karnataka set up by the Government of Karnataka. (See Appendix II)

13. In October 1988, CHC facilitated the first Trainers Dialogue organised by Voluntary Health Association of India at the National Institute of Mental Health and Neurological Sciences, Bangalore. Twently two participants representing various community health training groups in the voluntary sector of the country gathered for the first time to share experiences and discuss issues of common interest and concern (Report available from VHAI, New Delhi on request.)

14. As part of a process for lobbying for change the mfc `Anthology of ideas' was circulated by us in CHC, to the Deans/Directors of a few key medical colleges as well as a few other faculty and resource persons. A number of interesting interactions and some dialogue through correspondence took place through this process.

    i) We had a series of discussions with Prof. P.Zachariah, of CMC - Vellore who evolved the Miraj manifesto of a 'Community based medical college' through a sabattical interaction with the faculty of Miraj Medical Centre and extensive discussions and visits with resource persons all over the country. CHC sent a formal response to three questions put by him, which are included in Appendix III. To explore the diversity of options we looked at the `positive' and `negative' aspects of all the questions.

    ii) CMC-Ludhiana had started many initiatives towards an experimental parallel curriculum and in its final application for such a curriculum in 1990, it submitted the mfc Anthology of Ideas as part of the alternate experiment. CHC initiated a dialogue with CMC-Ludhiana, including a visit to meet the faculty and had many discussions with Dr.Alex Zachariah, Principal and key catalyst of the initiatives.

15. In 1989 the Christian Medical Association of India (CMAI) facilitated a Network of four Christian medical colleges (CMC-Vellore, CMC-Ludhiana, St.John's Medical College - Bangalore and the Miraj Medical Centre). At the first meeting of this network in August 1989, RN from CHC was invited to give the keynote address which was entitled `Towards Greater Social Relevance' (See Article F). The paper later published in the CMAI journal gave a historical overview of the medical education reform process in India, a summary of the key developments of relevance in the present and outlined a series of challenges for the evolving network in the future.

16. In 1990, 1991 and 1992, CHC participated in the ongoing deliberations of the evolving network of Christian Medical Colleges - which discussed a wide range of issues including ethics both institutional and teaching in medical curricula, formation of teachers, response to the challenge of AIDS, value orientation and so on.

17. In September 1990, CHC participated in the planning and organisation of a National workshop on the theme `Towards a Decentralised Health Care: A fresh look at the National Health Policy' organised by the National Institute of Advanced Studies, Bangalore. The two areas in which CHC presented papers during the wide-range of discussions were `An alternative vision of Education for Decentralised Health Care' (See Article G) as well as Research Priorities for Decentralised Health Care.

18. CHC has been planning and compiling on invitation, one issue every year of Health Action (the monthly publication from Health Accessories for All Trust, Secunderabad). In 1988, it was on Community Health, in 1989 on Rational Drug Use and in 1990 People's Participation in Health Care.

    In June 1991, we put together a special issue - Medical Education where does it lead ? which included the key cover story entitled Training of Doctors for India and articles on History of Medical Education in India; the challenges of continuing education; Medical Ethics, medical malpractices and patients' rights, the Kottayam experiment; the experiment in `Samaritan Medicine'; the Edinburgh Declaration; and reflections by students and interns of various community based alternative programmes.

    The special issue was mailed to all the health professional training institutions in the country, viz., allopathic, ayurvedic, homeopathy, and also to training institutes for nurses, pharmacists, physiotherapists, dentists and vets.

19. In April 1990. CHC initiated the project entitled `Strategies for Social Relevance and Community Orientation of Medical Education - Building on the Indian Experience'. This project was sponsored by CMAI (New Delhi) and CHAI (Secunderabad) and supported by the Network of Christian Medical Colleges.

20. In October 1991 the CHC team (now the functional unit of the newly registered and autonomous Society for Community Health Awareness, Research and Action) facilitated the second meeting of Community Health and Development Trainers in the Country to reflect on the issues arising out of the recently circulated Draft National Educational Policy of Health Sciences and to evolve a `Statement of shared concern and evolving collectivity'. This statement and proceedings were circulated to all the participants concerned as well as its key policy makers in the country.

The CHC Medical Education Project sought to weave into its report many of the ideas and outcomes of all these initiatives described earlier. (See Table I). The project ended in March 1992. A Faculty Resource Manual which will be one of the main outputs of this project, is scheduled to be completed and released in 1992. The project got inspiration and perspective derived deeply from all these earlier steps.

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SUMMARY : TABLE I

TOWARDS AN APPROPRIATE MEDICAL EDUCATION

- Step by Step

YEAR	INITIATIVE	PUBLICATION/REPORT
1972	Refugee Camp Experience	Making Medical Education Relevant to the needs of Society - Interns reflections (B)
1973	DTPH Dissertaion	Training Doctors for Community Health Services (Trends in Undergraduate Medical Education in India)(C)
1973-83	Community Orientation of Medical Education - SJMC, Bangalore	Moving beyond the Teaching Hospital (E)
1977	MD - Term Project	The Kottayam Experiment: Training programme for Community Nurses/Health Supervisors
1982	Year of Travel and Reflections with Community Health Action initiators at Grass Roots	Notes on a year of Travel and Reflection in the context of Social orientation of Medical College education (D)
1984	mfc Annual Meeting on Medical Education - Calcutta	Background paper (150 years of Medical Education: Rhetoric & Relevance)
	Workshop for Rural Bond Scheme Pioneers	Report of Workshop for Rural Bond Scheme Pioneers(Appendix I)
1988	CHC Network - Sub Committee on Medical Education	Memorandum on Health University (Karnataka Government) (Appendix II)
1989	Network of Christian Medical Colleges	Keynote Address: Medical Education: Towards greater social relevance (F)
1990-91	mfc Anthology - Medical Education Re-Examined	3 Articles in Anthology including Anthology of Ideas (Alternative Framework) (Appendix IV)
1990	NIAS Workshop on Decentralised Health Care & National Health Policy	An Alternative Vision of Education for Decentralised Health Care. (G)
1991	Health Action(Special issue)	Training of Doctors for India

B. REFLECTIONS OF AN INTERN (1972)

INTRODUCTION

The history of Medical Education in India, reaching down over the decades - for over 100 years, has seen no major changes in its pattern, structure or adaption to the changing needs of Indian Society. The health needs of India are varied. Side by side we have existing the bullock-cart age where primitive practices of sanitation and hygiene result in a mortality of over 30% in the rural areas; and we have the jet age in our big cities where cancer, hypertension, Diabetes, Mental illnesses and other so called diseases of civilization are taking a heavy toll. In addition even after over two decades of Independence and National planning, the problem of uneven distribution of Medical personnel i.e. 20% of Doctors in areas where 80% of the population resides, still continues. This is irrespective of the increase in number of medical colleges from 25 in 1947 to 97 in 1971 and the annual admissions from 2000 to 12000. Since our Medical Colleges continue to be located in the urban areas, the needs of the rural populaton have been sadly neglected and in addition the concept of community health even in our urban areas has not been adequately stressed by these colleges. Therefore the greatest need in India today is _

1. To make Medical Education more community oriented.

2. To reorient clinical training to prepare our young doctors for work in Rural areas.

BASIC DOCTOR

The present system of Medical Education serves admirably to train our young graduates for work in our large city hospitals modelled on the British and American pattern and not in our rural and semi-rural community centres. The needs in a rural area are very different from those in an urban society. "In the urban areas one can accept the responsibility for a limited group of people knowing well that others can seek and obtain equivalent advice and care elsewhere but in rural areas a doctor must accept responsibility for a large number of people often quite beyond the possibilty of his own personal management acknowledging that if he declines this responsibility he deprives them of all sources of medical help". In order to work in a rural area therefore a doctor must be what the Government of India defines as a "Basic Doctor" - i.e : "one who is well conversant with day to day problems of urban and rural communities and is able to play an effective role in the curative as well as preventive and promotive aspects of regional and national health problem".

SHORTCOMINGS IN THE PRESENT SYSTEM

The present system makes the young medical graduate 'professionally incompetent' and 'emotionally unprepared' to face his new role in the community because of the following shortcomings:

1. Education is not Community Oriented :

Medical Education in India is very hospital oriented and not community oriented. The doctor does not learn to treat his patient within the context of his life in society but on the basis of brief encounters in the wards. He loses sight of the fact that the stress and strain of everyday life affects the patient both in health and disease and if this is not taken into consideration the treatment becomes one sided.

2. Academic Environment of Institutions :

The environment in nearly all the teaching institutions is highly academic where each person endeavours to work in as narrow a field as possible. This stress on specialization leads to the fragmentation of a patient, making medicine more organcentred. The student therefore prefers to specialise rather than take up general practice.

3. Stress on Curative Medicine :

Too much stress is laid in our teaching hospitals on curative medicine and little or no stress on the preventive and social aspects. A student studies these aspects through a course of didactic lectures but no attempt is made to make these concepts a practical reality with reference to the cases in the ward.

4. Foreign Bias in Medical Education:

The textbooks we study are all written by foreign authors whose experience is based on cases and facilities present in their hospitals. The student thus develops a foreign bias and is not able to reorient his knowledge to suit the special needs in our rural areas or even in our smaller urban communities.

COMMUNITY ORIENTED MEDICAL EDUCATION

To make our system relevant to the needs of our society certain changes have to be introduced in our present patterns of training. In this paper the changes are suggested in order, from the pre-professional year to the period of internship. Many of them have been suggested in other papers on this subject in the last few years and repetition is unavoidable. All these suggestions have been discussed with students and all of them have been found to be acceptable to them.

a) Pre-Professional Student Counselling:

All high school and pre-university students planning to take up medicine as a profession must be counselled :-

i) To make them aware of their responsilibity to society.

ii) To prepare them to meet the special demands of the long medical course. This measure will prevent wastage of potential medical personnel due to chronic failures caused by disinterest and emotional inadequacy. Also for girls who do not plan to pursue their profession after marriage this counselling would help them to choose other less demanding professions.

b) Pre-Professional Course :

The present pre-professional course is to a large extent an unnecessary repetition of the higher secondary or preuniversity course. All the subjects taught are not adequately medically oriented :

i) In Botany or Zoology the stress should be on understanding the basic principles of human anatomy and physiology by a study of similar structure and function in plants and animals.

ii) In Physics and Chemistry - various aspects of so-called Biophysics and Biochemistry should be stressed.

iii) The student should be prepared for his role in society through lectures in certain aspects of sociology, anthropology, elements of economics, statistics and biomathematics even at this stage.

c) Pre-Clinical Course :

1. Anatomy and Physiology form the basis of our medical education and the content of these courses cannot be radically altered except that the teaching should be less cadaver-oriented and more clinically oriented. The student must be exposed to clinical material to help him understand better the normal anatomy and physiology of an individual and the changes in them which constitute disease.

2. The introduction of Preventive & Social Medicine at this stage is very welcome. The student must be taught about Nutrition, Environmental, Industrial and Personal Hygiene, Population Dynamics and National Health problems and programmes. A systematic course in the social sciences i.e. : in Sociology and Psychology at this period of training will make the student aware of certain duties towards the community which are overlooked during the hospital training.

d) Clinical Course :

It is during this period of training that medical students can be made most community and `rural' conscious. Though the hospital is the centre of his training an attempt should be made with the help of a well organised community health department to shift the emphasis of training and research from the hospital to the whole community in which the hospital resides. This can be done by :

1. Clinical bed-side teaching must take into account the preventive and social aspects of diseases encountered in the wards and the student should be encouraged to study these aspects in each case. e.g. : In a case of T.B.

i) a follow up of the patients contacts must be made.

ii) at the time of discharge the patient and his family must be educated on the health measures to be taken to prevent spread of the disease.

iii) a study of the socio economic circumstances in which the patient developed T.B. should be made. This will help students to understand and appreciate all aspects of a disease and its treatment.

2. Throughout the course in addition to the ward training the students, in batches must be made responsible for the primary health of organised groups in society like school and college students, children in orphanages, inmates of destitute homes, rehabilitation centres, prisons and in the big cities even of localised slums. The stress should be on primary health care and mass screening. After his first clinical year the student will be in a position to take keen interest in such activities. One of the criticisms of hospital training is that the students are not given enough responsibility in the treatment of the patients. The above scheme would help them to shoulder this responsibilty and make them more conscious of their usefulness in society. Recently the Bangladesh Refugee problem gave many of our interns and students an opportunity to voluntarily accept the responsibility of a large number of people for a certain time and this has been a very rewarding experience.

3. A Rural orientation is necessary in order to prepare a student for work with rural conditions, culture and traditions and the psychology of villagers. This can be done by :-

i) a study of an Indian Textbook which should be prepared on the lines of the book "Medical care in Developing countries - a symposium from Makerere - Nairobi which is based on African rural conditions.

ii) Practical training in rural areas for upto 6 months during the clinical years and 3-6 months during the period of internship.

4. The Preventive & Social Medicine Department which would also be a Public Health or community health department has a very important role during the clinical years. In addition to the coordinated activities suggested above students should be helped to conduct surveys and studies in the field-work areas in nutrition, infant care, maternal welfare and in diseases like TB, Cancer, Malnutrition and Diabetes. The students could also be posted in this department for 1-2 months for participating in the above schemes.

e) Internship :

Finally it is during the period of internship that the young medical graduate will be able to determine how well oriented he is for work in the rural areas - if he is posted in a Primary health centre for 3-6 months. In the company of a senior doctor and his colleagues he will get a first hand

impression of the type of work in Rural Medical Centres, which will give him a background for possible village work after internship. Each Medical college could take over a few primary health centres or start its own rural health centres where such training could be imparted. This programme could be planned out with the Government District Health Officer so as to prevent too much overlapping in the health care of particular villages. In this connection the government scheme of supplying 50 bedded mobile hospitals to medical colleges to provide opportunity for rural work is very welcome.

f) Postgraduation :

According to latest estimates at least 50% of Medical graduates go in for higher studies either in the country or abroad. One of the main reasons is that young doctors who qualify have to compete with their seniors who are already well established in the urban areas. Therefore to enter this highly competitive field they feel the need of a postgraduate degree of specialization. If at this stage however the government offers certain incentive like "good living and working conditions, vehicle for field work, visits to specialised institutions in the country and abroad and opportunities for professional advancement by way of admission to postgraduate courses after completion of 2-3 years in rural areas", I am sure with the added background of rural orientation during the medical course the majority of our young doctors will opt for the rural areas.

In conclusion it can be said that the crying need of the moment in the field of medical education is to widen the horizon of the student from a severly clinical-patient oriented outlook to a wider, socially conscious community outlook and a student symposium such as this is a very constructive step in this direction.

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C. TRAINING DOCTORS FOR COMMUNITY HEALTH SERVICES (1973)

Medical education in India is at the crossroads. A time has come for a radical appraisal of the entire system and an assessment whether we are progresing in the right direction.

The post-independence burst of energy led to a remarkable growth in medical education which was, however, quantitative rather than qualitative. The aims and objectives were exalted from the very beginning, and the translation into performance would have been possible, only if all the medical educators and students had been paragons of dedication . (TAYLOR, 1970). By the end of the first decade, it was discovered that the doctor in India would have to be very community-oriented and that the hospital oriented system with a dichotomy of preventive and curative services, which we had inherited, would never produce the type of `basic doctor' we required. A reorientation of the system was, therefore, necessary.

Like the medical profession all over the world we, in India, were still `traditionalists' and resistant to change, and so the measures taken towards this reorientation were half-hearted and indicate only a partial solution. Volumes of papers and hundreds of speeches were made on the health needs of the village communities, and the need based changes required in the medical curriculum but "imitation of western patterns and anxiety to reach standards acceptable by the western institutions resulted in a blurring of vision to create and develop an educational pattern that would fulfil the expectations and needs of the rural societies" (RAO, 1966)

Most universities decided that adding a course in preventive and social medicine and providing time in rural health centres would be adequate measures to give students the required community health orientation. Many departments of preventive and social medicine, however, made pioneering attempts in evolving new concepts of community health training, (refer Table I) which helped to improve the status of the subject, in the eyes of the students and staff. The clinical departments were slow to respond and many continued to give the students a narrow hospital orientation, in the mistaken belief that the community health orientation of the student was the sole responsiblity of the preventive and social medicine department. The specialists continued to load the student with unnecessary details of their specialities, patterns of research followed the fashionable and sophisticated pathways of medical research in developed countries and, therefore, the medical colleges continued to produce doctors who preferred the organised and protective health systems of the hospitals, rather than the challenging task of rural service. Planners and educators appeared surprised at the reluctance of doctors to man the health services in the rural area, and it took them quite a time to realise that the fault was in the educational system, that neither trained nor prepared them for the task and often, actually, interfered with the development of self reliance and confidence required to meet the challenge of rural health centre service in India.

It would interest educators in India to know that the protected development of the undergraduate has gone so far in the British system that the TODD report (1968) made the following interesting observation.

> "Every doctor who wishes to exercise a substantial measure of independent clinical judgement will be required to have a substantial postgraduate professional training, and the aim of the undergraduate course should be to produce not a finished doctor, but a broadly educated man who can become a doctor by further training".

It is moot point, therefore, to consider that having adopted the British system, with subsequent minor alterations, whether we could afford to produce such `broadly educated men' who could serve the community only after years of further training - for this is the observed result of our present system. Another interesting questions that needs to be answered is whether we should reduce the largely futile dependence on expensive over-trained physicians, and experiment with new grades of medical workers. In its approach to the Fifth five-year plan, the Planning Commission (1972) states that

> "The emphasis in rural health will have to be on prevention, family planning, nutrition and detection of early morbidity with adequate arrangements for referral of serious cases to the district hospital. Such a multi-tier system cannot be built on a national scale on the basis of the present expensive system of prolonged medical education. In order to provide an adequate number of doctors for the Fifth plan programme, and as an advance preparation for a more intensive coverage later, it would be necessary to consider the revival of the 3-year medical diploma. Indigenous systems of medicine will also have to be utilized for the purpose."

The Government has, therefore, clearly indicated that the training of a new type of doctor through a shorter course is imminent in India. Though the details of such a course are outside the scope of this dissertation, it would be worthwhile to discuss a few principles that could be applied in planning such a course:

1. <u>B.Sc. = Rural Medicine</u> :

> The most important principle is that the proposed 3 - year diploma course should not be a revival of the earlier licentiate course which we abolished at the time of Independence. Since then the medical profession in India has been highly suspicious of attempts to revive condensed M.B.B.S. courses and training of what are often known as `near doctors' or `subprofessionals'. The object of the course should be to produce a doctor who is so specifically trained for rural health centre service that he becomes more qualified for that job than the average graduate M.B.B.S.. In fact, the 3 - year course should lead to a Bachelor's degree in rural medicine, and not be underrated by calling it a diploma, and making it appear to be a lower qualification.

2. Principles of Training :

The training of the new cadre of doctors should follow the principles suggested by ROSA (1964):

i) Approach based on local problems.

ii) Maximum use of community self help.

iii) Training must be in the environment where his future job will be (Rural health centre).

iv) Broad perspective of rural problems.

v) Efficiency in mass methods of treatment, vaccination and so on.

vi) Appreciation of economics.

vii) Strong basis in maternal and child health and principles and practice of health education.

viii) Training should be very practical and realistic. In fact ideally it should be two-thirds practical, and one-third theory.

3. Regional Planning :

The training of this new cadre should be regionalised and specifically oriented to meet the needs of the peripheral health services in each state. Close cooperation between the medical colleges of the state and the government health services especially the primary health centres and district hospitals should be encouraged.

4. Critically Evaluate 'Indian' Experience :

The findings of the Rural Health project at Narangwal (TAKULIA et al, 1967) and the long experiences of many departments of preventive and social medicine in the country, in the organisation and problems and training in a rural health centre setting should be closely studied before evolving the new diploma course.

5. Learn from 'non-Indian' Experience :

Such locally-oriented cadres of medical workers have been trained all over the world, and the experience of educators of feldhsers in U.S.S.R. peasant doctors in China, physcian assistants in U.S.A. (DUKE UNIVERSITY SCHEME) and medical assistants or Health Officers in Fiji, Tanzania, Malawi, Sudan, Uganda, Ethiopia, Kenya and Nigeria should be consulted in the planning of the new course. These are described in FENDALL (1972) GISH (ed. 1971), KING (1966) BRYANT (1969) TITMUSS (1964) AND WADDY (1963).

6. Selection Procedures :

Selection of students for this course should be carefully done.

Stress should be on a rural background, a command of the local language, a familiarity with the people and a commitment to return to the rural area for work. Stipends should be made available to these students during their training, and on completion they must get jobs as close as possible to the areas from which they were selected. The village panchayats could also help in the selection of the right type of students.

7. Course Objectives :

The content of the course should be practical and realistic. The training must prepare the rural doctor for the three vital functions (FENDALL, 1972):

i) To act in a screening capacity and refer to more highly trained professionals, patients in need of greater diagnostic acumen and skills.

ii) To treat visible sickness and cater to simple health requirements such as routine midwifery, simple sanitation, water and housing improvement.

iii) To render emergency medical care.

8. Teaching Staff :

The teaching staff on such a course should consist mainly of health officers and teachers who, themselves, have a personal experience of rural health centre services.

The challenge, put bluntly, is that health services and systems of education must be organised for the good of the people, and not to meet the personal needs of a certain cadre of doctors for material gain or scientific satisfaction (TAYLOR 1970) and if a shorter course producing a new type of medical worker specifically trained for the rural areas is the answer, then we must have the courage and commitment to go through with the changes required. Only when the needs of the rural areas are met, can the claims for Social Justice within our constitution be validated.

It must, however, be remembered in India that the decision to consider a revival of a shorter training course for doctors does not mean that the existing M.B.B.S. course be allowed to continue to develop along western trends. The decision to reorient this course to meet the needs of our expanding community health services, taken many years back, has resulted in many healthy trends attempting to make the course more relevant to our local needs, and this must continue. The product of the system whether he wants to be a general practitioner, public health officer, specialist, teacher or research worker, must be made aware of the

local needs of his country, the economic limitations, the socio-cultural factors that determine health trends, and the need to develop local knowledge, local technology and local expertise. He must be made to realise that

> "no matter how useful a heart surgeon may be in the right situation, he is of little value in a country where thousands of infants still succumb every year to infectious diarrhoeas, and it would be far better if his talents had been turned towards a more useful, if less spectacular direction ". (MARGUILLES, 1966).

The process of making the existing medical education in India more relevant to the country's needs is well under way (See Table I) but unless these new programmes and methods of teaching are introduced with a degree of urgency into every medical college, the effect of the reorientation will be difficult, to assess.

TABLE I

Reorientation of Medical Education for Community Health Services (1973)

Initiatives

1. Creation of Departments of Preventive and Social Medicine
2. Community based Family Care Programmes
3. Course in Population Dynamics and Family Planning
4. Rural and Urban Field Practice Areas
5. Rural posting in Compulsory Rotating internship
6. Integrated inter-disciplinary teaching
7. General practice unit in teaching hospital OPD
8. Mobile training cum service hospitals
9. Student and Staff Health Services

It must be remembered that for such an orientation to be successful, we need staff trained in preventive and social medicine and in the expanding field of community health, and there is an acute shortage of such a cadre. Certain principles to be followed in this continuing reorientation should be stressed here.

1. University Involvement in Health Care :

Bryant (1969) has said that systems of health care are inseparably linked to the education of health personnel, and these systems cannot change without corresponding changes in education. What is needed in India today is a strong commitment of universities and medical colleges to health care in the surrounding communities. A medical college must not consider itself a purely academic insitution, but must be actively involved in the health of the community. A first step towards this commitment should be the allotment of a primary health centre, and its subcentres to each medical college in India. The college should not only use the centre for teaching, but also be responsible for its administration

and for the delivery of comprehensive health care to the villages; thus teaching and service become closely linked. Greater involvement in health projects in urban areas like urban slum health schemes, school health services, health of specialised groups in societies such as destitutes, prisoners, industrial workers, could also be initiated. Finally, a medical college situated in an urban area could be responsible for the total medical care of that region, both urban and the surrounding rural areas.

2. Improvement of Standards of Teaching and Teachers :

In India, as in all developing countries, there are acute shortage of well trained medical teachers. Most teachers take up teaching because they have been unsuccessful in private practice, or as specialists they feel that contact or association with a medical college improves their status and prestige. Teaching is thus seldom taken up as a vocation. This is unfortunate, since the teacher is a key-figure in the educational process.

Medical teaching in India can be improved, only if the following measures are taken.

a. Teachers must be given a training in the basic principles of education and must know how to produce effective results with the available facilities.

b. They should be full-time so that teaching becomes the main responsibility and not a side issue.

c. In order to get good teachers, the salaries must be improved, and their social status raised. Even the most dedicated teachers can be put off by the present salaries offered in India.

d. The teacher must be, himself, aware of the needs of the community, and must be acutely concerned with problems of health care and delivery in India. He cannot pass on a social concern to the medical student he teaches, unless he, himself is so motivated.

3. Documentation of Local Knowledge and Needs and Development of Local Technology. :

Any system of education which continues to follow textbooks, primarily written for, and dealing with the needs of a western community, cannot hope to produce students aware of local needs and disease conditions. Textbooks of medicines specially geared to features of disease and measures for treatment prevention and control available in the country are, therefore, urgently required. An Indian medical student, especially if he is expected to serve in the rural areas, must, surely, know more about Hookworm Anemia, Amoebiasis, Malaria, Tuberculosis, Leprosy and Malnutrition, than the information given in the textbook of medicine by DAVIDSON. At the same time he need not study, in detail, diseases such as Disseminated Sclerosis or Pernicious Anemia which he seldom sees. A special textbook or manual of medicine to prepare him for rural health centre service on the lines of KING (1966) would be very welcome. Attempts to develop local technology to design and produce medical apparatus and equipment suited to our local needs, budgets and climatic conditions should also be encouraged.

4. Appreciation of Economy and Effective Utilization of Available Service and Resources :

Health is only one of the many priorities in socio-economic development and hence the financial resources available for health care, education and development are limited.

In a developing country, like ours, appreciation of economy and effort to initiate building constructions, and health programme which are realistic, must be stressed. Often due to social and political pressures we are tempted to build large medical colleges and hospitals purely along western standards and designs. Very often these prove to be `white elephants' which are difficult to staff and administer, but more often than not, the building takes up the entire budget and so remaines unutilized due to shortage of running expenditure. This situation has occured so often in India that there is an urgent need to ban any further investment on such projects. In a country where the need is great, the quality and extent or care provided is far more important than the aesthetics of size of the institution through which it is given.

"For a proper and effective utilization of the available resources, it would be necessary to coordinate the activities of the various health institutions in a region. In this way, duplication of effort and wasteful expenditure on personnel and equipment could be avoided" (MONTERIO, 1970).

This also means greater utilization of existing private and public nonteaching hospitals and medical institutions, clinics and dispensaries in medical education.

5. General Practitioners and General Practice :

To meet the health needs in India, there should be a much greater emphasis on the production of general practitioners rather than specialists. This can be done by:

i) Introducing general practice units in hospital out - patients, as suggested earlier.

ii) Involvement of general practitioners of the area in the teaching and training programmes of medical colleges (MONTEIRO, 1970)

iii) Starting of a general practice speciality or department in every medical college which coordinate (i) and (ii) and also provides training for all medical graduates interested in taking up general practice.

6. Evaluation :

It is necessary to determine the efficacy of many of the earlier suggested changes in the curriculum, on the reorientation of students towards community medicine. Unless these programmes are subjected to well-planned evaluation studies, the effect they have on a student can never be determined. The only known study carried out on rural internship, for instance, is that by TAYLOR (1966). The study revealed that 71% of the interns questioned thought the rural experience was useful, 69% developed an ability to establish rapport with the villagers, 57% learned to get along with other professional colleagues and auxiliaries, 56% got an understanding of the socio-economic factors in disease, and 50% got a favourable idea of rural life after the three month programme.

7. Motivation of the Medical Profession :

All over the world there has been a gradually increasing materialistic orientation of the medical profession. The ideals of service and dedication are becoming rarer among the doctors. The outward manifestations of this change are reflected by the shortage of doctors willing to work in rural areas all over the world, by the shortage of doctors willing to work in specialities like geriatrics, psychiatry, or any field which requires a certain amount of dedication and also in the development of health care systems such as in the U.S. where the treatment one receives depends entirely on how much one can pay; thus a time has come when the medical profession must reappraise its own position in society. The young medical student plans his career in the image of his teachers and elders in the profession and unless their motivation changes, the hope of producing community oriented doctors remains idealistic.

However, it is important to keep in mind that the motivation of doctors to work for society in different countries is closely related to the political systems and, therefore, a particular experiment works in a country, only if the political system favours it. Finally, it must be remembered that health care and medical education are only one of the many aspects of the entire life of a country, and the more commensurate they are with the country's economic, cultural, social and other conditions, the more likely they are to succeed. They also stand a better chance of influencing favourably those other conditions. A village health centre is no longer a curative dispensary but a centre providing comprehensive health care which includes curative, preventive and rehabilitative measures, environmental health, improved nutrition, housing and recreation; in other words it is a centre involved in the overall improvement of the life of a community. Therefore, a doctor must be trained not only to be the head of a health team but must be prepared to be a member of a larger developmental team of, administrators, farmers, engineers, teachers and so on, united together in an effort to improve the conditions of Rural India.

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Source: Final chapter of Dissertation Trends in Undergraduate Medical Education in India - Training doctors for Community Health Service. submitted to London University for Diploma in Tropical Public Health, June 1973)

(D) LESSONS FROM A YEAR OF TRAVEL AND REFLECTION - 1982

1. Background : 1982 was an important milestone in our professional lives. After a year of travel to 'grass roots' health projects and a series of individual and group reflections on the challenges and dilemmas of community health, we decided to move beyond the portals of a medical college to initiate a technical resource centre in community health focussing our efforts on community health action and health activism. This note tries to highlight the salient features of the reflections and the reasons for our moving beyond the teaching hospital.

2. During the years 1973 - 1981, the Department of Preventive and Social Medicine of the medical college in which we were teaching passed through a rapid phase of growth, in response to the institution's renewed commitment to rural reorientation of medical education. During this phase seven rural centres in which there were both health and development efforts were organised. A unit of Occupational Health geared to training and research programmes in the plantations of South India was also established. A comprehensive rural internship programme as well as rural orientation camps for pre-clinical students were evolved. A wide range of informal, basic and continuing education efforts for community health workers, doctors and nurses from rural health projects and small hospitals, plantation medical officers and other plantation health staff were also developed during this phase.

3. The work was most interesting and the field experience rich and varied. The leadership of the department and the institution was farsighted and progressive and most of us in this phase got experience that was not only relevant but very comprehensive too. Few institutions in this country can boast of the phenomenal range of programmes that were built up systematically during this phase.

4. However, over the years, we began to sense a growing alienation which we soon realised was both conceptual as well as process related.

   The conceptual alienation was with the focus and setting of Preventive and Social Medicine as a subject in the context of medical care and education. The teaching of the subject was academic and examination oriented. Numerous compartmentalised topics had been put together under its banner. In the absence of integral links with the teaching hospital and adequate insitutional commitment to effective, community field practice areas, the subject did not succeed in making any impact on the attitudes of students or faculty of other departments and was gradually becoming just another subject speciality rather than the means towards a more comprehensive preventive and social orientation of medicine.

5. The process-oriented alienation was linked to the mechanism of the growth of the department. It seemed to us that there was a quantitative growth of staff, facilities, courses and field practice areas without a qualitative growth in planning, research, staff enrichment and programme monitoring and evaluation.

New and pilot programmes soon became routinised and due to a constantly changing staff pattern, the working of the department often became ad-hoc and one of crisis management. Programmes initiated as means to an attitudinal change, gradually, became ends by themselves.

6. We soon realised that some of these problems arose from the inability of most medical college managements to understand and plan effectively for rural/social reorientation of medical education.

Firstly, this reorientation process was most often misunderstood as the effort of a single department rather than concerted efforts of the entire faculty of a medical college. The stress was, therefore, on programmes by PSM department rather than innovative modifications in the teaching, service and research efforts of clinical and all other departments.

Secondly, there was always a dichotomy between the investment and inputs into a clinical ward and those planned for, in a community field practice area or community ward. This was not only in terms of available senior faculty but, also in terms of supportive staff, facilities and budgetary sanctions.

Thirdly, there seemed to be insurmountable obstacles in linking the community field practice area with the teaching hospital in an effective referral services complex as envisaged by the Government of India report on Medical Education and Support Manpower (Srivastava, 1975)

Fourthly, the needs and exigencies of transportation by a community medicine department team was an area of much misunderstanding.

Fifthly, in the absence of a perspective plan to commit adequate resources to a field practice area, to enable a team of staff to live in the area and evolve an effective community programme to be used for teaching purposes, much of the staff involvement in the community was remote control, tending towards 'armchair community medicine'.

In spite of the fact that the thrust in these years was very much towards a process of rural reorientation all these factors continued to play their part in the evolving situation even in this college.

7. Of all the programmes mentioned earlier, it was the informal training of community health workers, alumni doctors from rural hospitals, nurses from rural dispensaries and plantation medical officers, that gave us maximum job satisfaction and a sense of fulfillment. These training programmes gave us adequate scope for experimenting with non-formal and innovative training methodologies using a group dynamic, problem solving approach. Supporting such groups, who would actually be undertaking work in the community seemed more

fulfilling than preparing medical students or nurses for an examination. This informal, alternative experience also helped us in becoming critically aware of the inadequacies of our didactic, rather compartmentalised medical education system.

8. Over the years we also gradually moved in our understanding of health from its historic medical connotation of `sickness care' to the broader, positive definition of physical, mental and social well being.

We became more aware of the socio-cultural and political determinants of a health system and its close links and interactions with the development process. It seemed to us that whereas the medical profession would continue to mop the overflow of preventable illnesses through curative measures, serious health professionals and workers should and could initiate processes to turn off the tap of disease and ill health at its very origins in the individuals life style, attitudes, family life, community life and environment.

As these ideas began to dominate our thinking, we began to get more interested in a wide range of areas and issues not covered by orthodox medical education, viz., alternative approaches to health care; issues related to development and socio-political change; team building and group dynamics; informal and non-formal pedagogy; non-drug positive health therapies; non-allopathic systems of medicine including folk medicine; cross cultural conflicts in medicine; holistic health and so on.

All this supported a paradigm shift within our own perspectives from `sickness care' to `health'.

9. Inevitably an active involvement with the field realities of urban and rural field practice confronted us with social issues of poverty, inequality and injustice. This confrontation of value systems, life styles, attitudes and modes of team functioning and decision making was at both a team level and a personal level. Swinging between the mat-level simplicity of the rural centres and the ivory towered affluence of the college and hospital was a constant tension.

Working with and among rural people also heightened our sensitivity to the impersonal and dehumanising medical culture of our large, highly westernised model of college and teaching hospital. It also made us more than aware of the cross cultural conflicts that the poor patients experiences when they visit the hospitals from rural areas or urban slum.

10. Over the years, our interest in the newer dimensions of health brought us in contact with a large number of groups and agencies like the medico-friend circle, Voluntary Health Association of India, SEARCH, Indian Social Institute, Society of Young Scientists, Science for the villages, CREST and Family Welfare Centre, Catholic Hospital Association of India, CMAI and Asian Community Health Action Network. We

participated as members or resource persons in meetings and networking sessions. The awareness of the large numbers of people committed to health work outside the formal governmental or university network was a great support.

11. In 1981, some arbitrary decisions by the University affecting the student community led to a crisis in the college. During this period we had the opportunity to organise a solidarity movement to raise public opinion and the general conciousness of the campus residents on such arbitrariness of authorities. Apart from gaining some experience of the dynamics of organising such a collective action, it also gave us an understanding of the types of motivation of staff and students on the campus. At a deeper level, we understood an even greater evolving crisis that the insitution was running into -- in which the dimensions of lack of communication and motivation; lack of continuity in processes and planning and decision making; lack of participatory decision making; lack of inculturation and value formation; and pursuit of excellence out of the context of the pursuit of social relevance were going to play an increasing part.

12. All the above factors led to a certain degree of work related personal frustration and an increasing desire to rethink our role in medical education and health care. We therefore decided to 'drop out' of the college for a year and spend it visiting health and development projects in the country, meeting friends, colleagues, and community health workers, as a process of reflection and evaluation of our own personal work experiences and perspectives since graduation.

Overview of 1982 :

13. The year 1982 with all its component activities was a rich and meaningful experience for both of us at a personal level and well served its main purpose.

We visited a whole range of field projects and met committed people from differernt ideological backgrounds which helped to widen our horizons. The contact with a wide circle of people actively searching for ways and means by which health and development could be more meaningful for people especially the rural and urban poor was inspiring.

We met alumni of our college working in small rural mission hospitals and reflected together on some of the inadequacies of the medical education in our alma mater with specific reference to challenges of rural hospital practice.

We met community health workers in their own project setting and observed the successes and failures of our training programmes. We identified pressures that were pushing individual CHWs beyond their capacity. We also became aware of the deviations from our training as well as its overall limitations especially when individuals were working out of context of a supportive infrastructure.

We met medico-friend-circle colleagues and a whole range of health and development activists, who were involved with evolving a wide range of alternative projects and processes with the people. In our discussions with them, we focussed on understanding their work in a process sense as it evolved through positive and negative experiences. The interactions gave us a rich feed back of the imperatives of health and development work in our social reality.

We read and reflected on many issues concerning our vocation in greater depth than had been possible in the earlier years. We searched for answers to many technical and social questions facing us and though we did not always arrive at a definite conclusion, we discovered points of contact with the experience of others and identified processes through which more meaningful answers could be obtained.

14. Being a personal quest, the effects of which we hoped would be reflected in our future work, we did not plan to write a formal report for the institution as such. However, we list out here some broad perspectives which evolved as learning experiences from the year. It is impossible to share the whole experience just in a few paragraphs but the following perspectives highlight the salient conclusions of the search.

SOME PERSPECTIVES

15. The positive physical, mental and social dimensions of health, both at an individual and community level have failed to capture the imagination of the medical professionals and medical educationists because of their historical pre-occupation with `sickness care'.

Years of a `floor mopping' attitude to the overflow of disease has resulted in what has been described as `highly sophisticated curative practices along with all the paraphenalia of mystification, professionalisation and total submission to the dictates of the drug industry'.

The new `tap turning off' attitudes in response to the people's needs as well as potential available knowledge consisting of such ideas as --

primary health care;

health education;

demystification of medicine;

popularization of health producing activities and attitudes;

strengthening of people's traditions of self care;

community organisation and participation in health care.

and so on therefore continue to be viewed with suspicion, resentment and intellectural opposition.

The ethos of medical care and education, in rurally oriented medical colleges like ours and others we visited during the 1981 trip as well as most of the health services under non-governmental voluntary agency auspices continue to reflect this myopic medical view.

16. Ill health in the ultimate analysis is a direct product of an unjust socio-economic political system which results in poverty and inequality of resources and opportunities. A health team/health project/health institution, if it is clear in its `health' objective should inevitably become part of a development process which seeks solutions for issues of social injustice of which illness or disease are but a symptom. Health work would therefore become a development of alternatives by which this process of democratisation is extended to the grass roots, enabling people to shape and run their own health services. The team/project/institution must internalise this democratic process within its own structure as a pre-requisite. Hospitals, dispensaries, medical colleges and academic health departments which are products of existing structures need much internal change before they can participate in such a process. For a start they can become less hierarchical, less elitist and more sensitive to people, especially the poor and more participatory.

17. Those of us who function at technological levels in our professional capacities need to respond creatively to people's needs and evolve alternative and appropriate frameworks of technology, manpower, processes and communication, within the constraints in which our people live. Mobile clinics, rural camps, hospital outreach programmes and other such ideas which get doctors/nurses out of institutions into the realities of rural village and urban slum life are therefore only means. The ends being the adaptation of specialised knowledge and technical skills to the situation of people's lives.

18. Especially in medical colleges, when such ideas are experimented with as part of a rural reorientation process, it is crucial to ensure that they are evolved through a flexible process which stimulates voluntarism and creativity. Otherwise what has happened in most situations is the thrusting of frustrated, resentful faculty into a situation outside a hospital setting where they dish out limited stock of pills to a curious general public. Each department needs to understand the levels of care in the health pyramids, the types of workers available and adequately reorient their own teaching to `the best possible use of these resources under each circumstance' rather than `the pursuit of an ideal unrelated to social reality'.

As examples of this flexible creativty one may suggest initiatives such as : -

- pre-clinical department faculty organising human biology teaching in village schools;

- an OBG Department organising learning sessions for dais and ANMs;

- An anaesthesia department experimenting with simple procedures for field anaesthesia including acupuncture;

- a plastic surgery department organisinng a burns prevention education programme in a village school.

A mobile clinic programme would then become a means to such creative reorientation and as and when each department identifies a more concrete, more socially relevant role in the community, it could move beyond the mobile clinic. Only if such creative interactions and freedom of innovation is made possible can medical college faculty ever grow out of their ivory towered isolation. It must be kept in mind that social/community orientation is a first step towards the preventive and promotive reorientation of medical roles.

19. It is common place for professional institutions to talk of social relevance, rural reorientation and so on. However, more often than not, these have been attempted by a whole series of adhoc. unintegrated activities representing ideas of individuals rather than a thoughtfully analysed, planned process of change involving collective discussions among faculty.

Changes in attitudes, objectives and even professional direction can be brought about only if the institutional management or term leaders are sensitive to process. This is as true of rural projects, small peripheral hospitals, large specialist hospitals or even a medical college. A social reorientation of its activities and objectives can evolve gradually through the acceptance of a need for : -

i. an understanding of the historical process and growth of an institution/profession/activity;

ii. the overall social context in which it operates and the new values or vision it wants to move towards;

iii. a setting of clearly defined, measurable objectives;

iv. a participatory planning process which involves formal and informal feedback and evaluation as an integral component;

v. a team building approach in decision-making;

vi. a stress on the development of the human resources of the team rather than material resources and structures;

vii. a shared value system which shapes attitudes and evolves practice of individuals within the institution/project;

During the year of travel we came across some institutions and projects who were going about this social reorientation

in a serious systematic way and it was through an interaction with them that we understood all the components of such a process.

20. Team work, professional, or social in any endeavour decides ultimately its success or failure. This was an important learning experience. Many programmes though committed to health in community had not internalised "healthy team" functioning within their structure and the effects of this incongruence were obvious. Highly individualised efforts pushed in a non-participatory set up were not uncommon where orientation to achievement, overshadowed team development, ultimately sensitive to this dimension, having arrived at its need not always without a crisis in the project/team. However, by realigning the objectives and methodology so that team members were enabled, enriched and actively encouraged to participate, they were beginning to move towards more integrated efforts. This dimension was as true of the interaction between team members, as it was for the interaction between team members and villagers or the community. A partnership in development if it has to be truly in a spirit of dialogue must go beyond divisions of professional /non-professional, expert / lay, educated /illiterate, medical/ non-medical, provider/beneficiary and so on. That this was happening at least in some projects was a good experience to observe.

Some aspects of this team work dimension that we collated from various expereinces were:

a. evolution of mutually shared common objectives and roles through group work;

b. a concentration on strengths of individuals rather than weaknesses;

c. increasing opportunity for sharing of ideas, feelings, hopes and experiences;

d. a constant effort to internalise a shared value system eg., in community health oriented efforts. This may include healthy life styles and attitudes, community feeling, simplicity, non-hierarchical functioning, learning from the people, adapting technology etc.;

e. an informality and openness in inter-personal relationship;

f. a commitment to learning from field experiences of the entire team rather than just "theory". This would automatically mean a commitment to constant experience analysis, critical reflection and review;

g. an inculcation of participatory management in planning and decision making.

Though much of this may seem unrealistic at first, in our present highly institutionalised set up, we discovered

through interactions with even institutionally based people that institutions or structures by themselves were not stifling or limiting of such a process.

The major block was the formality of ideas with which individuals and decision makers choose to function within them. It was thus an attitudinal constraint not a structural one.

21. One of the greatest dangers to any process of social change, reorientation, relevance seeking endeavour is a rapid setting in of institutionalisation including:

- routinisation of activities;
- formalisation of functions/relationships;
- increased red-tape;
- fixity of roles;
- fear of precedence;
- discouragement or disregard for informal and formal feedback;
- lack of adequate communications;
- inability of leadership to encourage, enrich and support team members.

What was surprising was that many people saw team work as a genetic attribute of individuals not an environmentally stimulated response. However, many others had discovered that "good teamwork" does not just happen. It needs to be planned for and worked for. We even met teams who were moving from a phase of hierarchical functioning to a phase of participatory functioning patiently relearning attitudes and seriously questioning past modes of functioning. That this was possible was heartening.

22. Having been part of a phase of rural reorientation of a medical college before we embarked on this year of travel and reflection, we could not help but critically review and reflect on the process we had been part of. Some overall perspectives that emerged were: -

a. rural reorientation of medical education is a term that needs to be changed since the need is not just to focus on a geographical setting as an end in itself but to focus on socio-economic and cultural factors and issues relevant to health care. These are important in the context of the community interaction outside the hospital but are equally important factors within the context of hospital functioning. The effort thus becomes a social and community orientation of all aspects of an institution's efforts.

b. the focus of efforts must not be to get Staff and students to just physically move into rural areas as an educational or service effort but to challenge and change attitudes within the profession and institution stimulated by the perceptions from the community experience. These attitudes would include: -

- desire to humanise hospital environment by humanising medical team - patient relationships, and improving medical team-patient communications;

- encouraging demystification of medical knowledge and health education;

- increasing sensitivity of hospital staff to conditions of poor patients, the socio-economic factors under which they operate and the cultural realities of their lives;

- making our technology subservient to people's needs - not making people subservient to professional, technical, institutional needs. The latter is possible only through a continuing system of social audit of institutional services.

c. Such attitudinal changes which is the crux of all efforts can seldom be brought about by orders, bonding, pressures, monetary incentives, or indirect coercion or disincentives even though each of this may have a temporary effect. The change can be brought about only by: -

i. increasing role models in the institution by better staff selection;

ii. open discussion and democratic decision-making;

iii. a constant and continued exposure of faculty and students to all those already involved in such work;

iv. analysing of positive and negative field experiences through a problem solving approach;

v. a creative and flexible encouragement to all suggested initiatives by faculty and students.

d. An attitudinal change is a sensitive process and is one area where the counter-productivity of hastily applied, impractical, irrelevant, often super-imposed methods should be constantly kept in mind and avoided, eg., inadequately prepared or

undersupervised field exposure, planning insensitive to the community's feelings and needs, publicity consciousness in efforts and so on. Such efforts often result in a growing cynicism which is more difficult to tackle in the long run.

23. It is important to record here that these perspectives were gained visiting people working both within formal and informal institutions, projects and networks in health, development and education. In all of them there was a healthy dialogue of whether existing team-institutions can really internalise some of these newer perspectives and processes within the existing constraints and established relationships and modes of functioning. In other words, can a medical college, a department of an existing institution, technology or specialist oriented hospital, a curative oriented peripheral hospital, even a bureaucratised health project, actually change their attitudes to support and build people's health and people's initiatives to gain greater autonomy over the structures/processes in society that can promote their health?

Can existing ethos and frames of references of medical insitutions change so that rather than continuing as "providers of medicine" they could become "enablers of health".

Source: Notes From an year of Travel and reflection (1982) - a cyclostyled handout circulated to peers and friends (CHC)

E. MOVING BEYOND THE TEACHING HOSPITAL (1989)

A Reflection on Some Efforts Towards an Alternative

Reorienting Medical Education to prepare doctors for community based health care in rural areas has been an interest of mine ever since my internship experience in 1971, in a camp near Calcutta, for refugees from East Pakistan (now Bangladesh). After three semesters of cadaver oriented pre-clinical studies and six semesters of hospital-oriented clinical studies, I discovered that my skills to meet the health needs of 6000 refugees squatting on less than an acre of land, were rather limited. This was a thought-provoking experience and I was left with nagging doubts about the `high technology', `drug', `institutional' and `foreign' orientation of our medical education. During my public health studies, I reviewed 25 years of reforms in Medical Education in India (1947-72) and studied the experiences of introducing Preventive and Social Medicine departments, rural internship, slum based family care programs, integrated inter-disciplinary teaching and the use of mobile clinics and general practice units. All these were interesting ideas added to the inherited edifice of medical education - mostly tinkering reforms, not a radical revision or reorientation. Most medical teachers were products of the same hospital-oriented system and lacked community health orientation. Little real change in attitude could take place.

From 1974 to 1983, I participated in a decade of efforts by the Department of Community Medicine of my alma-mater (a socially oriented medical college in South India) towards rural orientation.

We had to function within the existing constraints of the University curriculum and the guidelines of the Medical Council of India, but these proved to be less of a hindrance to experimenting with creative alternatives than we had thought, initally.

The challenge before us was to move beyond the orthodox `banking type', fact-filled, disease-oriented curriculum to a more experiential, participatory, problem-solving exposure in the community.

Students and interns had to be put in touch with the social realities of rural India. The educational stimulus had to be geared to both the `thinking' and `feeling' domains of learning.

Processes initiated at the field level had to be flexible to allow the student and/or intern to grow with the experience of reality, countering the dominant hospital-orientation and medical culture.

I describe briefly two initiatives out of a larger number of experiments which proved to be challenging for most of the students and interns who participated in them.

The first initiative was a sensitization experience during pre-clinical studies before the medical student entered the hospital and underwent the brain-washing of the dominant hospital culture.

INITIATIVE 1 RURAL ORIENTATION CAMPS

A group of thirty pre-clinical medical students camp out in a village school in Karnataka with a few staff members of the Department of Community Medicine. The camp has a double purpose:

i. To get to know the social anatomy and social physiology of rural India and;

ii. To explore individual motivations, values and perceptions in a wider social context.

The ethos of the camp is based on group dynamics and participatory planning. During the two weeks the students go out daily in groups of twos and threes to visit families in the neighbouring villages and elicit information about various aspects of village life, through informal chats.

The first week focusses on community dynamics - agriculture, occupation, village government, health and education facilities, markets, transport and communication, the second week on family dynamics - caste, - culture and religious traditions, festivals, maternity and child health practices and KAP towards folk, traditional and Western medicine alternatives.

During the two weeks, discussions are organised with village leaders, school teachers, health and development service providers. Students interact with villagers during community events and festivals.

The focus of all the concurrent small group discussions is not only the "what" but also the "why" so that the deeper social dynamics are explored. Since many of the medical students, by nature of the selection process, are urban, middle-class youth, cross cultural conflicts and class prejudices in the interpretation of observations and in the evolving perceptions have to be tactfully challenged. Through simulation games, the complex life conditions in which the rural and urban poor operate and make decisions is experienced.

The two week experience increases social sensitivity and provides medical students to look beyond the medical college walls to existing social realities.

The second initiative described next was an experience during internship after final examinations were over.

INITIATIVE : RURAL COMMUNITY HEALTH CLINICS

Interns, who have completed a few months of hospital based internships are posted for three months in teams of two, to small, rural community health clinics in villages. These clinics are organised by the staff of the Community Medicine department, through mobilization of resources, initiatives and interest of the village communities and development agencies. The resource mobilisation is multi-pronged - finance through cooperatives, festival donations, contributions from banks and payment for services; labour; provision of clinic accommodation; accommodation and facilities for young doctors; time and participation of formal and informal leaders for decision-making meetings; volunteers and so on. The interns participate in all these efforts.

They are supported by weekly supplies of drugs, information, `morale', cold chain, sterilized equipment, by visiting staff members. A weekly MCH clinic is run by departmental staff. The interns are encouraged to organise school-based health programs, training in health and first aid for village youth, health-education programs, specialist camps. Initiative is primarily left to the interns, while visiting staff are merely facilitators.

The programs wax and wane with the varying motivation of the interns and staff but the open-ended approach promotes initiative and enthusiasm. Each intern undertakes a village based project - a survey or exploration of a health problem. The focus, due to time constraints, is more on methodology and home contact than on findings.

The principle and ethos of the program view the intern as a participant in a process not a `cog in the wheel'.

Many are challenged, many are enthusiatic, but all experience the stark realities.

Both these initiatives proved to be of much personal satisfation to staff and students. However, our experience over many years of this type of community programs showed that long term attitudinal changes vis-a-vis career options were not taking place. No doubt the participant of such programs would turn out to be a more socially sensitive doctor than the average product of a medical college in India. But his/her preference for an urban, high technology, specialist-oriented hospital base remained powerful.

What the experience primarily showed was that alternatives geared to innovations in the curriculum content of one department, however relevant, would have little impact. The whole ethos of the medical college would have to be changed and the participation of all the faculty of all the departments would have to be ensured. Such a process would ultimately lead to a

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radical reorientation of the selection procedures, course content, pedagogy and skill training in the institution. The new process would have to be located in a wider social context.

It is five years since I moved beyond the medical college to a process of reflection and facilitation of community health at the grassroots. Through the "medico friends circle" - a national network of doctors and health activists - a process has been initiated which seeks to outline an alternative medical education, deriving inspiration from the deeper analysis of historical and social forces at work in our society and in our educational process. The publication of these reflections is awaited. The findings are, however, beyond the scope of this reflection.

Source: LINK, Vol. 7, No 1, April- May 1988 (Special issue on Training - Newsletter of Asian Community Health Action Network).

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F.MEDICAL EDUCATION - TOWARDS GREATER SOCIAL RELEVANCE (1989)

1. Lessons from History :

The History of Medical Education in India spans several centuries. An interpretative history can be broadly divided into four key phases, during which Medical Education evolved and was influenced by the socio-cultural-political realities of the times.

a. Phase I -

(i) Ancient and Medieval India

India's traditional system of medicine, called 'Ayurveda' (Science of life) developed during the Vedic period. Training of doctors in this sytem was through apprenticeship to renowned physicians. Later 'Gurukulas' or Ashrams of learning were started with groups of pupils. Records are also available of atleast three institutes of Higher learning - Taxila, Nalanda and Kashi, where medical degrees were awarded. The authoritative textbooks or Samhitas included those of Charaka (the Physician) and Susruta (the Surgeon). The two most renowned medical teachers of those times were Atreya and Jivaka.

With the advent of the Buddha (500 - 600 AD) came the development of a hospital system for men and animals. During this period the materia medica which hitherto had been based mostly on herbal remedies, introduced mineral salts (Iatrochemisty). However surgery and human body dissection, for teaching purposes, experienced a setback during this time.

In a later phase (1200 - 1800 AD) Ayurveda and its component Medical Education experienced a growing stagnation due to lack of State patronage which resulted in poorly equipped and poorly maintained teaching institutions.

Records of the educational aspects of this long tradition show that the training methodology included theory and practicals - lecture, discussions, seminars, practical compounding, examination of patients and surgery. There were theory and practical examinations at the end of the course and a graduation ceremony where a medical oath was administered, similar to the present system.

Great care was taken in the selection of good teachers and students, in which both cognitive and affective qualities were given importance. The qualities of a good teacher apart from proficiency in the subject included a practiced hand, good observations, disposition to teach, able discussant, non-practicing, gentle, dispassionate, pure conduct, pain and privation bearing capacity and a person with no malice or wrath. On the other hand, the good student apart from having a broad based education and aptitude/intention for knowledge, needed to be patient, 'Dharmic', celibate, polite, non-violent, truthful, pure of body and mind and nonhaughty.

British colonalism on the other hand led to the establishment of the Madras General hospital in 1679; the Medical department of the East India Company in 1740; the training of local assistants dressers and apothecaries by IMS Doctors for the next eighty years; the development of the native Medical Schools in Calcutta, Bombay and Madras between 1824-1827 and finally the Committee on Medical Education appointed by Lord William Bentick in 1833 which saw the establishment of Medical Colleges all over India firmly on the European traditions and practice of those times.

The Native Medical Schools had a 3 year training in Pharmacy, Materia Medica, Anatomy, Physiology, Medicine and Surgery based on British textbooks and treatises which were translated into Sanskrit and Urdu - both of which were the medium of instruction. The works of Charaka, Susruta and Avicenna were also studied and we find here the first attempts at 'integration' of traditions. The recommendations of the Medical Education Committee of 1833, saw the defeat of the 'orientalists' by the 'Anglicists' especially through far reaching reform of colleges (4 - 6 years) with English as the only medium of instruction and the principles and practice of medicine taught being strictly in accordance with the European mode of practice and textbooks.

The colonial phase therefore saw the establishment of a colonial medical education cut off from local historial and cultural roots.

The phase 1833-1932 saw the establishment of the new type of Westernised medical colleges all over British India by the government, rajahs, businessmen, philanthrophists and eminent citizens. Apart from the subjects taught earlier in the native schools, Chemistry, Opthalmology, Jurisprudence, Dentistry and Hygiene were introduced into the curriculum. Colleges were affiliated to the newly developing Royal Colleges of London, Edinburgh and Dublin. Through a gradual transition, there was a socio-cultural acceptance by the Hindu and Muslim communities of all aspects of Western Medical Education including cadaver dissection.

Inspite of the 'Colonialist' dimension this phase also saw some 'positive' aspects, the significance of which cannot be underestimated.

Firstly, was the development of 'Public Health' practice which made a dent on many of the major killer diseases in India like Plague, Cholera, Small-pox and so on. Based on the European tradition this was a new dimension to the organised health traditions in India which till then had been mostly medical and individual-patient oriented. While these did not develop uniformly all over India but were concentrated mostly in and around the British cantonments and adjacent civilian areas, it still had a tremendous impact on the health of people.

(ii) = The Medieval Phase

The Moghul invasion in the 12th Century AD, led to the introduction of the Graeco-Arabic system established as Unani through a chain of medical schools and hospitals (bimaristans) all over India. Based on the Hippocratic tradition this system interacted with the established tradition and cross-fertilised it. Textbooks were translated into Urdu and medical education was through either apprenticeship or private practitioner linked schools or schools attached to big city hospitals. Pharmacy developed as an important and independent discipline and qualified pharmacists (Sadyalinatasi) and drug inspectors (Muhtasib) were appointed in the health services. The materia medica gave importance to minerals and metals.

While the medical education pattern was similar to that of the Ayurvedic tradition, great stress was laid on Medical ethics; full time teaching was considered an honourable profession; and the good qualities of a teacher included a good build, deft hand, eyes free from disease, not greedy, sensitive to dirt and pain and tears and strong minded but kind. Due to taboos in Islam, however, Anatomy and Surgery were neglected.

LESSONS

The key lessons from the system of Medical Education in ancient and Medieval India for medical educators of today include:

- the integration of theory and practice;
- the stress on healthy living and positive aspects of health;
- the careful selection of teachers and students, in which affective qualities were given as much importance as cognitive skill;
- the broad based, background education of students, and
- the close integral links of the education with local and established culture.

b. Phase II = Advent of Western Medicine

This phase which began in 1510 AD, with the establishment of the Royal Hospital in Goa saw the advent and establishment of the European tradition of medicine and medical education on the Indian sub-continent.

Portuguese colonialism led to the rudimentary medical teaching by Cipriano Valadares at the Goa hospital in 1703, followed by the 3 year course of Miranda and Almeida in 1801 and the establishment of the Goa Medical School in 1842 and the Naval Colonial School of Medicine in 1888.

the health services were key recommendations apart from the suggestion to abolish the licentiate course and have only one type of doctor - the MBBS doctor.

The Constitution of Independent India, adopted in 1950, accepted the 'Right of citizens to public assistance in sickness' and the newly developed Planning Commmission adopted the Bhore Commitee recommendations as the blueprint for planning medical aid, public health and preventive medicine in the country. (9)

The first All India Conference on Medical Education in 1955 saw the development of the scope, aim and requirements for Preventive and Social Medicine departments in all medical colleges, which would be the key facilitators for the social/community orientation of services and education, envisaged by the planners. The Mudaliar Committee - Health Survey and Planning Report, (1959), recommended consolidation of existing colleges along the lines already laid down and introduced the compulsory pre-registration internship as well as the concept of community field practice areas for PSM departments. In 1960 the Indian Association for the advancement of Medical Education was established and the Indian Journal of Medical Education launched. This association and journal became a forum for continuing dialogue on relevant medical education.

In 1964 the Medical Council of India spelt out the details of the PSM curriculum and also outlined some of the administrative, preventive and clinical objectives of rural internship. While encouraging social orientation through the above, it also tried to keep up with the West by suggesting introduction of Genetics, Bio-Physics, Electronics, Space Medicine, Molecular biology, Radio-isotopes and Nuclear medicine as well. In 1970 the Medical Education Committee (Patel) finally defined the Basic Doctor- the preparation of whom had to become the objective of undergraduate Medical Education in the country. (Refer Box 1)

BOX 1

The Basic Doctor

"Conversant with common problems of Rural and urban communities...

Able to play effective role in curative and preventive aspects of regional/National health problems...

Good clinician, comptetent to judge when referral is needed...

Able to give life-saving aid in all acute emergencies...

Constant advancement of knowledge through continuing education."

(Patel, 1970)

By the 1970s many Medical Colleges had introduced PSM Departments and had begun the recommended teaching and postings in rural and urban field practice areas. While most paid lip service to the detailed recommendations, many were serious in their attempts to re-orient the orthodox system. The developments of innovations by these medical colleges within the existing constraints included the establishment of a well-staffed PSM Department and its gradual orientation to the dynamics of community oriented field practice; the concept of a Family health Advisory service by medical students; the development of internship programmes for rural and urban field practice including family planning postings; the development of the curative/preventive/general practice (CPGP) units in medical college hospital OPDs; the development of the Mobile training cum service unit hospitals (the government sponsored Chittaranjan Mobile hospitals); the concept of student/staff health service and so on. (9)

Beginning in 1972, when the country celebrated its Silver Jubilee, a new introspective spirit was seen in Government documents and expert committee reports about the failure of the 'medical education system' of post-independent India making any impact on the social/community orientation of the graduate doctors or the health services. The V Plan document, the VI Plan Document, and the Srivastava Report (Report of Group on Medical Education and support Manpower, 1975) were all uniform in their indictment of the present medical education and its increasing irrelevance to the country's health problems and people's needs.

The Srivastava report made a very comprehensive analysis of the situation and diagnosed the problem as multi-factorial. (refer Box 2)

BOX 2

"Diagnosis of the Problem"

-"Stranglehold of the inherited system

- exclusive orientation towards the teaching hospital
- irrelevance of training to community health needs
- increasing trends towards PG degrees and specialisation
- lack of incentive/recognition for rural work
- attractions of the export market for medical manpower
- links of Medical Education to social framework is brought about only at the end of the course during the intership."

- Srivastava Report, 1975

It concluded that 'Medical Education postpones rather than prepares doctors for practice of medicine in the community' leading to the VI Plan document (1979) exhortation for the 'need to restructure medical educational programmes to change skills/knowledges/attitudes while restructuring society towards social justice'.

The late 1970s thus saw the end of this 'nationalist growth phase of Medical Education' with a growing disillusionment of the inadequacies of the attempted medical reform on the inherited western medical system.

LESSONS

A review of the development till 1979 (Narayan 1984) draws many lessons from this 'Nationalist Phase'.

Firstly, the 'colonial mentality' had been well established in the 'brown saheb' culture of independent India with planners and educators accepting separate types of services for rural and urban areas - for the classes and the masses.

Secondly, the populist rhetoric of health care for the masses while at the same time keeping up with the west in the urban areas had exposed our pseudo-socialism.

Thirdly, there had been a concomitant dilution of educational standards due to a growth pattern that had stressed quantity over quality.

Fourthly, the schizophernia in our educational objectives which included going west and going rural at the same time also had become evident and counterproductive.

Fifthly, teaching in medical colleges had not become a vocation and the qualities of the available faculty was far from satisfactory.

The overall stress of MCI recommendations had been on 'content' and not 'process' of education and as the MCI recommendations of 1981 themselves accept that there had been no evaluation nor experimentation on scientific lines..

Finally, the PSM departments which were considered to become the harbingers of change had, by their very existence generated some new myths which were becoming problematic for the system. Foremost among of these were that :

i. Clinical medicine and PSM (Community Medicine) were two different types of medicine and the latter was a poor quality, ad-hoc, community based version of the former.

ii. In addition community/rural/social orientation was seen as the responsiblity of the PSM faculty and not that of all the teaching faculty of the medical college.

It was no surprise therefore that, as these myths got well established the 'changes' in medical education made little dent in the attitude and orientation of the medical graduates.

It is unfair to draw only negative lessons from this important phase and one would like to record that, these thirty years of post-independence history, had also seen the establishment of some medical care centres and medical college departments - both undergraduate and post-graduate of excellent quality - their services and training, being second to none in the world as evinced by the fact that graduates of many of these centres were doing very well in their specialities and had received acclaim, both national and international. However, it is this very pursuit of excellence and high technology oriented medicine unrelated to social relevance and social cost which has heightened the disparities and dichotomies of the health/medical scene in India.

These successes notwithstanding, expert committees and national policy documents have been unversal in their acceptance of 'failure' and exhortation to 'change'. Foremost of these have been the Srivastava Report (1975) which calls for a

> 'conscious and deliberate decision to abandon the existing model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations.'

This was followed by the ICMR/ICSSR Health for All, Strategy report which endorses all the Shrivastava report recommendations and exhorts medical educators to

> 'abandon the flexnerised model of education' and adopt a holistic, inter-disciplinary approach' which is more field oriented and practical and which is based on a close collaboration of medical colleges with the health services.

Finally the 1982 National Health Policy Statement, the first in thirty five years calls for

i. Review of the entire basis/approach towards medical/health education at all levels in terms of national needs and priorities.

ii. Restructuring of curricular/training programmes to provide professional competence and social motivation for day-to-day problems.

II. Search for Greater Social Relevance

- The initiatives in the 1980s

The 1980s has seen a new spirit of introspection and innovation though it is too early to judge whether 'in the collective' these efforts will demonstrate a real concrete change in the situation or a continuation of the status quo promoted by a more strident rhetoric. However the 'need for change' is now an established fact..

The key developments and initiatives of this decade include the following.

1. The ICMR/ICSSR Health for All Report has outlined some aspects of an 'Alternative Health Care System' that needs to supplant the existing system (refer box 3). It is more than obvious that the 'orthodox medical education' system cannot prepare professionals to serve in such a system and therefore there is need for a concomitant development of an alternative system of medical education.

Box 3

A health care system which combines the best elements in the tradition and culture of the people with modern science and technology,

- integrating promotive, preventive and curative functions
- democratic, decentralised and participatory,
- oriented to people.....
- economical, and
- firmly rooted in the community and aiming at involving the people in the provision of services they need and increasing their capacity to solve their own problems.

ICMR/ICSSR, 1980

2. The Medical Council of India's curriculum recommendations of 1982 bring together all the previous key reforms and suggests even further innovation which support the gradual move towards an alternative.

The key recommendations include :

- Increased integration of course
- More fundamentals and less sophistication
- More community based education experience
- Emphasis on independence of judgement and self-education
- Reduction in didactics and increase in group learning experiences
- Focus on common community problems in all subjects
- Clinical teaching to be focussed on outpatients, emergency and peripheral health centres

- All faculty to be involved in rural centres

- Teachers training in Pedagogy and Community Health

The PSM curriculum was further strengthened and spread over the entire syllabus. It included three months of pre-clinical training including hospital and community/project visits, three years of concurrent PSM teaching during clinical years with practicals, field visits, postings in PHCs, rural hospitals and urban health centres as well as participation in preventive/promotive programmes. It finally recommends a 6 month internship experience in PHC's, peripheral centres, FP clinics and rural projects.

3. The ROME Experiment

Though launched by the Janata Government in 1977, the Rural Orientation of Medical Education programme finally got off the ground in the 1980s. Based on the Srivastava Report recommendations the experiment included the allotment of three PHCs per medical college and the provision of three mobile clinics to involve faculty and students of all departments in supportive services and field exposures in the community, moving beyond the teaching hospital. In principle this programme is a concrete step towards the community orientation of medical education. In practice however the experience has been varied but mostly negative. An evaluation by a JNU researcher in 1984 of the situation in two states - Karnataka and Haryana showed that the learning experience for students from this programme was nil, the wider objectives were ill-understood by both the students and faculty and there was official indifference as well from the concerned government health departments. A few colleges have reported positive experiences especially if they have used their initiative and modified the guidelines through experience.

4. The Kottayam experiment

An experimental project undertaken in Kerala in the years 1972-76 to create a new category of health worker - a liaison between the hospital doctor and the community evolved an aproach and curriculum which has great relevance to all those who are keen to experiment with an integrated, community oriented and field based curriculum. However being in the NGO/Mission sector this project did not have the larger impact it should have had and lead primarily to changes in the B Sc Public Health Nursing syllabus in Kerala as well as acted as a stimulus to the Health Assistants course in Tamilnadu and the B Sc Health Science course in Osmania University, Andhra. This project is unfortunately hardly known in medical education circles.

5. Innovations by serious medical colleges

While the MCI curriculum recommedations of 1982 provide adequate opportunity for innovation within the existing system only a few medical colleges have used this new opportunity for change. Atleast two medical colleges in the Mission sector CMC (Vellore) and St. John's (Bangalore) have been known to have tried out a varying range of programmes foremost of these being the Rural orientation programmes/camps for pre-clinical students and the socio-epidemiological community oriented block postings for clinical students and community postings for interns. JIPMER (Pondicherry) in the government sector has been another innovater. Though their efforts have not necessarily brought about attitudinal changes or community career options among the students to the extent intended, they have definitely provided meaningful inputs into a community awareness and orientation of the practice of medical graduates of these institutions, which is no small achievement.

6. The Medico Friend Circle.

An informal national network of doctors and health activists concerned about making health care and Medical Education more relevant to the needs of the poor in the country have focussed their attention on Medical Education through a series of meetings and reflections since 1983, stimulated by the efforts towards an alternative Medical School, by the renowned Gonoshasthya Kendra Project of Bangladesh. An Anthology of articles entitled 'Medical Education : Re-examined' which will soon be out of the press has among other things a first preliminary draft of an alternative curriculum. Will there be any takers !!

7. The Alternative Track

Stimulated by the experiments undertaken by members of an evolving International Network of Community Oriented Health Sciences Institution in the world, the idea of an Alternative track - an experimental parallel curriculum is being considered by MCI and a few institutions in the country since 1988. This would include problem based teaching of the McMaster University Model (Canada), Community orientation on the model of the ROME experiment in India and learner centred teaching pedagogy. The alternative track is expected to have 7 units of 7 months each, two devoted to human biology, three to Primary Health Care and two to tertiary health care. Though still in the planning stage, the experiment if it comes through will be a concrete expression of change. CMC Ludhiana, one of the participating institutions has been the most enthusiastic recepient of the idea.

8. A series of developments in the latter half of the 1980s other than the above show some potential for the future. The New Education Policy enunciated by the government in 1986 has several new thrusts which could have a bearing on the scope and content of technical education in the next decade.

A consortium of institutions including AIIMS (New Delhi), Benaras Hindu University (Varanasi), CMC (Vellore) and JIPMER (Pondicherry) have been formed in 1987 to explore 'Decision based approaches to Evaluation and innovation in Medical Education' based on the methodology enunciated by Centre for Educational Development Illinois (USA).

Two State Governments, Tamilnadu and Andhra Pradesh have operationalised the formation of Health University while a third, Karnataka is in the process of considering such a development. While the preliminary efforts have been mainly in the direction of standardisation of training and facilities, the possibilities for potential innovation in the context of health orientation are many.

The Department of Social Medicine and Community Health of Jawaharlal Nehru University has recently made a plea for a new Public Health and Medical Education which would stress historical perspectives; epidemiological approaches; political economy of health and add ecological/social/cultural dimensions to existing efforts.

The Miraj Manifesto towards an alternative effort prepared by CMC, Miraj is another concrete example of a new commitment to innovation.

The Phase of Medical Education in India committed to the evolution of 'alternative options' and 'social relevance' has therefore seen a good beginning in the 1980s and the next decade will see hopefully some committed alternatives to the goal of Health for All by 2000 AD.

III - Challenges and tasks before the CMC Network

In the first section I have reviewed the important events in the long history of medical education in India and drawn some lessons from the positive and negative dimensions of this evolutionary growth. In the second section I have focussed on numerous initiatives and developments in the 1980s which augurs well for the new phase of innovation and highlights steps towards a more relevant curriculum. This is particularly important since we are now entering the final decade of this century and have now set for ourelves the goal of 'Health for All by 2000 AD'.

The emergence of a network of Christian Medical Colleges, to dialogue together and explore new dimensions, collectively, is a positive step in the context of the future. In this final section, I will look at some tasks and challenges for the network.

The Christian Medical Colleges in India have played an important role in the establishment of model medical institutions committed to quality education, humane patient care, efficient administration and increasing commitment to community needs. They have pioneered historically medical education for women, hospitals and services for women and children, specialist and super-specialist education and community medicine orientation of undergraduate training among other things. However, in the past they have done this primarily as individual institutional commitments functioning primarily within their own universe (minority christian institutions) and focussing on the complementary network of Christian medical insitutions in the country. The staff and alumnus of these insitutions have in addition played a pioneering role in various professional associations and institutions as well as in the establishment of community oriented health projects and training in the country.

A time has therefore come to first to take stock of these achievements and the network could initiate sharing and dialogue sessions that explore the strengths and weaknesses of these achievements and initiatives. Learning from the experiences of each other and from the initiatives of their alumni could be a first task.

A second task is, they could move beyond the 'Christian experience' and learn from and explore with all those institutions, groups and initiatves that share a similar social commitment to patient care, quality medical education and community health.

A third task of the Network would therefore be to build a new ethos of collaboration and cooperation - building on the past histories and present strengths of each insitution.

These three tasks, which could be among the initial goals of the Network would help to re-examine the 'contributions' and 'developments' within the group of Christian medical insitutions and reaffirm those aspects of their shared value system and commitments that have shaped their evolution. They would in the process, especially with Task two identify and recognise 'partners' and initiatives within the wider secular Indian situation with whom future collaborative and supportive actions could emerge. This is particularly important since in response to the commitment of being 'leaven in the bread' - Christian insitutions have a role in focussing beyond their own insitutional needs and goals to the wider society in which humane values need to be established and strengthened.

Before discussing the fourth task, it is important to explore some disturbing dimensions of the health care services and medical education system which have been developing all along but have definitely shown an increase in the 1980s. While the earlier review of the 1980s in the second section, affirmed some of the positive developments towards 'rethinking and experiments with alternatives in health care and medical education' a series of simultaneously evolving negative trends have called into

question the future direction of health care and medical education in the country. Firstly, we have the growth of capitation fee medical colleges which link admissions to donations and fees for seats. While no one would deny the need for private enterprise nor parental/public support for funding technical education to support the government's role, the experience of these insitutions has been geared to exploiting the 'money factor' not only in admissions, at the cost of the merit student from a low income category, but in other aspects of training and development as well. Government institutions are being allotted to some of these institutions at the cost of government training centres. Taken together these developments reflect the politicisation of medical education

Secondly, there has been a growing privatisation of health care and a gradual corporate sector takeover of health. This has led to an increasing glorification of 'high technology diagnostics' and high technology medical care often at the cost of basic health care for the majority. There is an increasing 'doctor-drug producer axis' creating 'vested interest in the abundance of ill health'. The private practice orientation is spreading in government institutions and among medical college teachers and there is an increase in monetary considerations for 'services' as well as promotions, transfers and posting. All these symbolises the increasing commercialisation of Medicine.

While discussing Community/Social orientation of medical education as a new direction it is sobering to remember that the 'politicisation' and 'commercialisation' of health care and medical education is rapidly taking place in the country and therefore the fourth task of the network of Christian institutions would be to resist these forces by continuing to teach good quality, ethical, rational medicine' and exemplyifying it in their day to day insitutional practice - while at the same time searching for alternatives and exploring new dimensions in health care.

The fifth and more challenging task before the network is to use the 'collective opportunity' to critically examine all aspects of current medical/health care and evolve strategies and initiatives, to improve the quality, the social relevance, and the ethical and wholistic aspects of it. A whole range of issues would come under this collective scrutiny. Ethics, pedagogy, appropriate technolgy, rational therapeutics, rational investigations and surgery, health team concept, social vision, community oriented priorities, pastoral care, accountability, humanisation of medical care, spiritual values in institutional practice, participatory management, social justice within and outside institutions, health policy, quality assurance of health care and so on. The collective endeavour would also help to identify 'creative responses and ideas for institutional reorientation.

Finally and most significantly the network could seriously explore and experiment with alternatives in medical education as well as 'training of health manpower' which are more strongly committed to a social vision and a community orientation and are

more likely to provide the 'technical competence' and the 'emotional preparedness' of graduates to serve the needy and the underpriviliged in the most disadvantaged areas of the country. While this is in no way more significant than the other tasks outlined earlier, it would probably be the most relevant response to the Christian vision of 'preferential option for the poor' within the context of medical education.

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Source: Keynote address at First CMC Network meeting in August 1989. Later published in Christian Medical Journal of India Vol VI, April - June 1991, No 2

G. AN ALTERNATIVE VISION OF EDUCATION FOR DECENTRALISED HEALTH CARE (1990)

1. Background :

The National Health Policy seeks to provide 'universal comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementing of the various health programmes is through the organised involvement and participation of the community, adequately utilizing the services being rendered by private voluntary organisations active in the health sector'.

In the context of this commitment to 'decentralised' control of health care it identifies the need to review the entire basis and approach of current training programmes in terms of national needs and priorities and recognises the 'cultural gap' between people and the personnel providing care, brought about by the present policies.

It calls for a restructuring of curricular and training programmes towards community health orientation; integrated team concept; and towards professional skill and competence as well as 'social motivation' to 'handle day to day problems within existing constraints'. It emphasises the crucial need to monitor the process and review the efforts.

In addition it reiterates the need for a National Medical and Health Education Policy which would include suggested changes in curriculum at all levels; inter relationships between health functionaries; realistically assessed manpower requirements and efforts to correct regional imbalances and availability; as well as social motivation towards Community health Services.

Finally accepting that 'the recommended efforts, on various fronts would bear only marginal results unless there is a nation-wide health education programme'. it calls for 'public health education. supplemented by health nutrition and population education in all educational institutions at various levels', further complemented by 'promotion of universal education': specially adult and family education'.

Since it was the first comprehensive statement of policy, in nearly four decades it was an important milestone. However, if the content of the policy statement is critically analysed, we discover nothing new. From Bhore Committee (1946) onwards, through the Mudaliar Committee (1959), the Medical Education Committee (Patel,1968), the Kartar Singh Committee (1974), the Srivastava Report (1975) and the ICMR-ICSSR Health for All Report (1981) - all expert committees and policy recommendations have said the same thing: -

What : Need to reach all people with basic care
Need to involve people in planning/organisation
Need to transcend cultural gap

How: Review all training programmes
Change curriculum
Community Health orient and motivate all manpower
Assess manpower requirements and train realistic numbers
Supplement with Public Health Education

All these previous committees have made several volumes of recommendations - most of them adhoc and empirical but relevant all the same. Srivastava Report sums up the situation well : -

> "We have no dearth of ideas on the subject and if all the recommendations made by educational committees and commissions were put one after the other, instead of going round and round in circles as they often do, we may have a ladder stretching from the earth to the moon"

The report further adds that while the focus all along has been on educational content (type of change needed), there has been little attention to creating appropriate structures for educational change and hardly any attention to processes of initiating change and carefully nursing them to grow.

It is important to stress here that in keeping with the recommendations, some reforms have been constantly implemented at different levels in the last four decades. These include the creation of Preventive and Social Medicine Departments in Medical Colleges; the introduction of complusory rotating internship including rural/public health postings; the broadening of the scope of PSM teaching in Medical Colleges extending throughout the course; the experimentation with the ROME Scheme and so on.

Domiciliary midwifery and some degree of public health orientation was also included in the nurses training.

The creation of the cadres of Health Supervisors, multipurpose workers, trained dais and community health volunteers or village health guides and the establishment of the rural health and family planning training centres to train them was also a step in the right direction.

However impressive, the quantitative expansion of health manpower in four decades may seem the qualitative assessment of the situation leaves much to be desired. The Srivastava Report observes:

* "There is little congruence between the role of the physician and the needs of society, little equilibrium between medical education and health care.

* Medicine is still regarded essentially as an enterprise of Science and technology; the physician is the repository of all knowledge and dispensation; specialisation is the hall mark of progress; and the training ground is the teaching hospital.

* Doctors are still largely urban based and their distribution between states is uneven.

* The training of nurses has not made equal progress, even in numbers.

* Inspite of the 'vast proliferation of the number and types of para-medical personnel, the growth of the health care services has been haphazard and unrelated to the needs of the poor and rural people who stand most in need of care.

* Over centralisation of authority and compartmentalisation still plague the services.

* The health personnel structure is still distorted; instead of a pyramid it is more like an hour glass".

The end results of the efforts in Public Health Education have not been very promising either. Inspite of the setting up of the Central Health Bureau and State Bureaus in 20 States and Union Territories; the production of bulletins journals, technical reports and films by CHEB as well as diploma and short-term training programmes; introduction of the health education component in almost all the national programmes including the family planning programme, the report observes that

* Health attitudes of the people have hardly changed.

* Health education programmes have hardly made any impact on the situation.

* There is little rapport between the health services and the general education services - and neither of them have been able to reach the underprivileged poor.

* The programme of health education has remained anemic and academic.

Even though the Srivastava Report was commenting on the period 1975 and before - the last fifteen years have not seen any major or dramatic change in policy or implementation.

In 1989, the present government has committed itself to a radical decentralisation of the Health and Education Sectors. At this juncture we need to relook critically at the present situation of manpower education and health education, to understand the deeper issues of the malady and to explore approaches and processes that may help us go beyond the present situation of relevant recommendations, populist rhetoric, and inadequate reform.

2. SCOPE OF PAPER :

In this paper I would like to approach the whole problem of educational policy for a Decentralised Health Care by -

Firstly, providing a scenario of the present situation at the community level to which the educational policy must respond.

Secondly, I wish to highlight the salient and crucial dimensions that must find expression in the policy framework and formulation.

Thirdly, I wish to highlight certain positive initiatives and contributions that should be carefully studied to provide the concrete basis for reform and reorientation.

Fourthly, I wish to highlight certain important trends in the country which though inimical to the concept of a decentralised health care are well established and need to be countered by such a policy.

Fifthly, I wish to provide a Philosophical matrix against which all efforts in Education for Health have to be contextualised, so that the process initiated, is both responsive and relevant, to the socio-economical-political-cultural realities that exist in the country.

3. THE 'COMMUNITY SCENARIO' :

The policy of Panchayatraj and the formal involvement of people in the planning and implementation policy, through it, has been on the books for years but has been concretely attempted at the grassroots mainly in Karnataka and West Bengal in recent years.

The village community today, as before remains a heterogenous community stratified by class, caste, gender, religion, geography and education.

Health Care Services are inappropriate culturally and inadequately accessible to most. Where accessible it focusses and caters to those who have money or power and it is they who will participate in any decision making in health if at all in the Panchayatraj System, at the community level.

The large majority of landless and marginalised are unreached by the primary health centre services for the same reasons that affects their involvement in education, development or political power.

The local health traditions, folk medicine and indigenous systems of medicine and the dais provide some cure and relief. Where this is inadequate or fails, they (poor) are forced to find relief in the growing private sector in health often at the cost of wages and increased indebtedness.

The Primary Health Centre doctor and the team of health supervisors and multipurpose workers are unable to respond creatively to this reality due to many reasons of which three are crucial.

In background and values they are alienated from the large majority of the village under-privileged.

Their training and skill development is in a training environment heavily influenced by the 'medical model' and strongly curative and technological in its orientation.

They have little understanding of social analysis or societal processes or of participative pedagogy or awareness building techniques.

In addition being part of a top-down, centralised, hierarchical planned and vertically implemented health care system, they are mostly preoccupied with the targets and measured actions in Family Planning or immunization or other selectivized primary health package deals.

The doctor who leads the team is emotionally unprepared and professionally incompetent to handle the situation and therefore fills his time with private practice, coercive health education, statistical jugglery and health team policing if he is not visiting the Directorate, seeking an urban transfer.

The health team has little understanding of the sociological or epidemiological dimensions of the local situation, since the over 20 records and registers maintained and tabulated, are primarily for a monthly statement transferred to a district MIS that is preoccupied with providing invalid statistics for the State, Central governments and Planning commission rather than for critical education and decentralised planning at the grassroot. Decentralisation of Health Care must locate itself in this rather unfavourable climate.

4. DIMENSIONS OF EDUCATIONAL POLICY :

If an Educational Policy has to make a dent in a situation, such as the one described above, then it must be responsive and creative in a host of ways.

a) Basic Manpower Training

* The Doctors, nurses and paramedical auxiliaries have to undergo basic training in an environment which is more community oriented and community based than at present and which provides 'professional skill and competence' and 'emotional preparedness' to practice medicine and health care in conditions of limited resources and difficult environment, seeing it as a professional challenge / opportunity rather than an unavoidable obligation. Field practice areas outside the teaching hospital have to be facilitated and all the faculty oriented to provide meaningful learning experiences to the trainees.

  Though the curriculum of each member of the team has to be reviewed and suitably modified the so called Community Health Orientation which is so often

mentioned in policy documents should consist of a core curriculum which would involve a) Social Analysis, b) Orientation to Local Health Culture and Indian Systems of Medicine, c) Holistic inter disciplinary Problem Analysis, d) Experience of Alternative Pedagogy, e) Participatory Management, f) Appropriate Technology, g) Interactive and qualitative Research and Monitoring, h) Socio Epidemiological Orientation, and i) Awareness building and Health Education Skills.

b) Continuing Education:

* While reform is basic training in a long term solution and a distant possibility, the existing PHC team has to be given a well planned and creative reorientation programme as a commitment to continuing education which will seek to convert them to a new development culture including the following components among others

  * The recognition of people as 'participants' and not 'beneficiary'.

  * The importance of a Social/Societal analysis to help in a positive discrimination towards those groups who do not participate in or utilize the present systems.

  * Skill and competence in an information transfer, health education and awareness building process.

  * A sensitivity to feedback from people and an increased commitment to learning from grassroot experience - personal or that of co-workers.

  * A sociological and epidemiological orientation that helps to move understanding and initiative from individual to collective/community levels and encourages a more holistic problem analysis.

  * The recognition of diversity of options and flexibility of approaches.

  * The appreciation of interactive and qualitative approaches to programme evaulation and not a preoccupation with quantitative indicators.

  * An adaptability to modify or create technological options to suit local situations.

c) Participatory Management Education :

* At both basic and continuing levels the whole process of education should promote an integrated team concept and promote a process of collective discussion and decision making and counter, actively the present day values and characterstics of hierarchical functioning, individualism, gender

discrimination, education/profession linked superiority and so on. This will enhance not only the intra team interactions but will greatly encourage a more democratic / participatory interaction with the people and representatives of the community which is the basis of Panchayatraj. If health team members do not experience this democracy in their training programmes or their day to day PHC functioning, they are unlikely to be motivated or skilled to facilitate this at the level of the community.

d) Community Education :

* Even if, through reforms in basic training and a commitment to continuing reorientation of existing PHC staff, we are able to encourage the formation of professional/skilled manpower to facilitate the demands of decentralised Health Care there is still the equally crucial task of community education. The people at large and the formal and informal leaders in particular have to experience an awareness building and orientation programme which has to go way beyond the 'lecturing' or 'telling them' style of leadership training camps presently organised by the Health Department for Family Planning and Immunization. These sessions need to be dialogue based and using audiovisual techniques that are low cost and folk culture sensitive. The rush to use TV and Videos as a short term solution must give way to a more purposive focussed and interactive process reaching all those who do not get reached at present. The use of puppetry and street theatre, folk arts and festival entertainment, jathas and street corner meetings or shandy exhibitions etc., need to be widely promoted and utilized. The experience of the peoples science movements in Kerala and Maharashtra and other NGO media groups is very relevant to these efforts.

e) Health in Primary Education :

* Finally while interactive civic education and health education directed at the present polity must precede decentralisation a comprehensive input of health/nutrition/and population education must find an important place in all educational efforts - formal and informal at all levels and particularly but primarily, at a school level so that future citizens, more attuned to the participative demands of a decentralised health care are available. School health programme actively involving children and teachers through creative 'learning by doing; techniques is a crucial input.

While all these suggestions may appear at first, to be not dissimilar to many offered by experts and others before, there is a qualitative difference in the scope, focus and orientation of the process being suggested. What has failed in the past is not just the content but the process of education and the pedagogical culture. it is this 'alternative' culture that is being stressed in this paper.

5. AN OVERVIEW OF ALTERNATIVE EDUCATIONAL EXPERIMENTS IN INDIA :

There is a tendency in the country for experts and educationists to make adhoc and empirical generalisations about curriculum change without promoting active experimentation or evaluating ongoing initiatives or for that matter substantiating through micro-level practice at least the validity of the suggested reforms. Most are not even aware of what little experimentation is actually going on. It is true that for a country as large as ours with a contigent of nearly 300 medical colleges - nursing colleges and - paramedical training institutions, the quantum and quality of relevant experimentation or reorientation efforts has been rather limited. There are however still numerous projects and initiatives that have explored crucial dimensions and need to be seriously studied by planners and policy makers to evolve an educational policy for Decentralised health care on more sounder foundations.

* The description of these initiatives in any detail is beyond the scope of the paper but a brief overview is required (refer Appendix I) to atleast substantiate the contention that there has been experimentation as well as record appreciation for these efforts, inspite of the prevailing bureaucratic, highly centralised and professionally controlled, medicalised, hospital oriented, educational environment.

* These alternative experiments have taken place both within and outside the profession educations system. The innovaters include teachers in medical colleges and community health trainers in the NGO Sector. Coordinating groups like CHAI, VHAI, CMAI and issue raising health activist groups like mfc have also organised programmes or developed alternatives.

* Outside the health sector a number of alternative training experiments have emerged in the informal education and development sector that have relevance to health manpower training or public health education.

* All these trainers have experimented with more participatory forms of training and generated a number of case studies, role plays, simulation games, learning exercises and community based problem solving techniques that provide a firmer foundation to the educational programme outlined earlier in the context of promotion of decentralised health care.

Having been closely involved with training in both the formal and informal sector for nearly eighteen years, I am convinced that there is available a wealth of alternative pedagogical experience that could be tapped by the health planners and policy makers to make the suggested educational programmes a concrete reality.

Presently in fact a few of us are part of an interactive research project that is putting together this rich Indian experience into a handy 'reference manual of local innovation,

an Anthology of ideas emerging from local experience, and a resource directory of local expertise'. Hopefully this will be of great relevance to the health 'manpower trainer' and public health educator who wish to organise education programmes to support the policy initiatives towards decentralised Health Care.

6. BROADER ISSUES IN THE CONTEXT OF EDUCATION OF HEALTH :

Education for Decentralised Health Care cannot take place in a vacuum. It must be contextualised to the emerging social-economical-cultural-policitcal realities and trends in the country. Notwithstanding a growing commitment and enthusiasm among health planners and policy makers to the concept of Decentralised Health Care, especially in more recent months, there is no doubt that there are larger more disturbing trends emerging in the Health Care Scenario, which can neither be ignored nor brushed aside as unimportant and which are basically inimical or counter to the whole decentralisation trend. Only two of these will be highlighted here, though there are many more.

Firstly is the growth of capitation fee medical colleges which link admission to donations and fees for seats and which have also geared the money factor to other aspects of training and institution development.

Linked to these is the growth of institutions based primarily on communal considertaions. Both these types of institutions continue to get state level recognition inspite of objections by MCI and Central Government. Government institutions are being allotted to such groups at the cost of government training programmes. These trends reflect the increasing politicisation of Medical Education.

Secondly there is a growing privatization of Health Care and a gradually increasing corporate sector takeover of health. This has led to glorification of high technology diagnostics and high technology medical care often at the cost of basic health care for the majority. There is an increasing 'Doctor-drug producer axis' creating a 'vested interest' in the abundance of ill health. The private practice orientation is spreading in government institutions and among medical colleges teachers and there is an increase in monetary considerations for 'services' as well as promotions, transfers and posting. All these symbolise the Commercialisation of Medicine.

Both 'Commercialisation' and 'Politicisation' are not accidental. They reflect both government policy action and inaction and are leading to a gradual erosion of the values among health manpower and the disappearance of good, rational, ethical, medical and health practice. This is a cause for serious concern and urgent policy counter offensive. Decentralisation of Health Care and involvement of people in Health Care decision making, planning and organisation will remain policy rhetoric if these wider more ominous trends are not checked in time. All of us committed to HFA - 2000 and to the increasing involvement of the Community in their own Health Care, cannot ignore these trends.

7. THE PARADIGM SHIFT :

Having outlined a multi dimensional educational response to the promotion and support of the concept and policy of Decentralised Health Care which would include a) Community Oriented Health Manpower Training, b) Community Health Orientation of Trained Manpower, c) Public Health Education and Leadership Orientation and d) Health in Primary Education and having also suggested a 'core' of 'issues' and 'dimensions' that must form an integral part of the 'community health orientation' and 'social motivation' at all levels and in all these training programmes I would like to conclude with a final suggestion.

All efforts in Education in Health in the 1990s must be located in a paradigm shift that has been taking place in our understanding of Health and Health Care from the orthodox medical model to the social model of health that attempts to tackle ill health at its deeper roots.

This Paradigm shift is characterised by a multi-dimensional shift in emphasis - in all aspects of health, health care research and training as shown in the accompanying box:

THE PARADIGM SHIFT

Medical Model to Social Model of Health

INDIVIDUAL	--->	COLLECTIVE/COMMUNITY
PATIENT & POPULATION	--->	PERSON & SOCIETY
PHYSICAL/MENTAL PREDOMINANTLY	--->	PHYSICAL/MENTAL/SOCIAL/ CULTURAL/POLITICAL/ECONOMICAL
DOCTORS/NURSES MEDICAL AUXILIARIES	--->	TEAM OF HEALTH WORKERS
DISEASE PROCESSES	--->	SOCIAL PROCESSES
HOSPITALS/DISPENSARIES DRUGS/TECHNOLOGY -PROVIDING SERVICES	--->	HEALTH PROMOTING AND COMMUNITY BUILDING CENTRES AND PROCESSES- ENABLING/EMPOWERING THE PEOPLE
INTRACELLULAR RESEARCH	--->	SOCIETAL RESEARCH
PATIENT AS BENEFICIARY AND CONSUMER	--->	PEOPLE AS PARTICIPANTS
PROFESSIONALISED COMPARTMENTALISED MYSTIFIED KNOWLEDGE	--->	DEMYSTIFYING, PERSON CENTRED AUTONOMY CREATING AWARENESS BUILDING KNOWLEDGE
QUEST FOR VACCINE AGAINST DISEASE	--->	QUEST FOR AWARENESS BUILDING PROCESS TRO IMMUNIZE AGAINST UNHEALTHY SOCIAL PROCESSES.

The success of the strategy of Decentralised Health Care and the educational efforts to bring it about will depend very much on how effectively health planners, policy makers, educationists and researchers and the health team are able to adapt themselves to this changing matrix.

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ADDITIONAL NOTES

TRAINING EXPERIMENTS RELEVANT TO THE NEW EDUCATIONAL VISION WITHIN THE SYSTEM

* A few medical colleges in the country have experimented, with community orientation, within the constraints of MCI recommendations and though the multi-dimensional efforts, may not have produced a marked change in long term career choices among their graduates for community health, it has definitely provided some of the 'professional skills' and the 'emotional preparedness' that expert committees have mentioned as being crucial. Foremost among them are CMC-Vellore, MGIMS-Sevagram, SJMC-Bangalore, AIIMS-New DElhi, JIPMER-Pondicherry and CMC-Ludhiana. Two of these CMC-Vellore and SJMC-Bangalore have a rural placement (bond) scheme that ensures that many of their graduates serve 2 years in a peripheral community oriented hospital project and render meaningful service.

* Many departments of medical colleges have experimented with providing 'learning experiences' beyond the 'teaching hospital' through rural orientation camps, rural/urban family health advisory schemes, rural/urban field practice areas and block postings; curative and preventive general practice units rural-urban community based health education programmes, socio-epidemiological projects, mobile training cum service units and extended community based rural internship.

* The Jawaharlal Nehru University has organised M.Sc., M.Phil. and Phd. programmes in Community Health which goes beyond the orthodox public health or preventive and social medicine postgraduate programmes to provide students with a historical perspective, epidemiological approach, political economy of health as well as a sensitivity to focus on ecological social and cultural dimensions in health efforts.

* The Medical Council of India and a few institutions have been working on an experimental parallel curriculum which is problem based, learner centred and community oriented. One of these institutions, CMC-Ludhiana, has already been given the green signal by the Punjab University to go ahead with the alternative track from July 1991.

* A consortium of institutions including AIIMS (New Delhi), BHU (Varanasi), CMC (Vellore) and JIPMER (Pondicherry) has been formed in 1987 to explore 'Decision based approaches to Evaluation and innovation in Medical Education' based on the methodology of CED ILlinois, a US based -WHO linked resource centre for Education innovation.

* Two State governments, Tamilnadu and Andhra Pradesh have operationalised the formation of Health Universities. While the preliminary efforts have been mainly in the directions of standardisation of training and facilities, many potential innovations in the context of health orientation are possible.

OUTSIDE THE SYSTEM

* The Kottayam Experiment in 1972-76 created a new category of health worker as a liaison between the hospital doctor and the community through an integrated, community oriented field based curriculum - which was a pioneering effort.

* The medico friend circle - an informal national network .of doctors and health workers has recently brought together an alternative medical curriculum entitled 'Anthology of Ideas', which explores the broad framework of a community oriented and community based medical college. This is derived from an anthology of reflections on medical educaton by some of its core members entitled Medical Education Re-Examined

* The Miraj Medical Centre has formulated a plan of a Community based Medical Education experiment, circulated recently as the Miraj Manifesto and is awaiting the go ahead from Central and State Authorities.

* After years of Primary field level experience many community health training programmes have emerged in the voluntary/NGO Sector focussing on Community health orientation and skill development for medicos and non-medicos. Varying from 6 weeks to 1 year they all promote community organisation and development, community participation, demystification of medicine and training of local health workers. Key among them are the leadership course in Community Health and Development (Deenabandhu), Community Health and Development Course (INSA, Bangalore) Diploma in Community Health Management (RUHSA and VHAI), Diploma in Community Health (Ambilikkai), Community Health Planning, Organisation and Management Course (VHAI) and others.

* In addition to the above NGO health trainers there are a growing number of training and orientation courses in non-health, development sector which have evolved content, pedagogy and attitudinal orientation of great relevance to health manpower education as well. The SEARCH Apprenticeship in Development (Bangalore), the TRACE animators course (Maharashtra), the initiatives of the Behavioural Science Centre (Ahmedabad) and the training programmes of Indian Social Institute (Bangalore and New Delhi) as well as ICRA Bangalore are examples of such courses.

Source: Proceedings of the National Workshop on 'Towards a Decentralised Health Care : A fresh look at the National Health Policy, National Institute of Advanced Studies, September 1990, (In press)

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APPENDIX I

FEEDBACK FROM PIONEERS OF A RURAL BOND SCHEME (1984)

A. BACKGROUND :

In the last few years some graduates of St.John's Medical College (SJMC) have undertaken the two year rural placement scheme organised by SJMC in coordination with the Catholic Hospital Association of India (CHAI). To-date little over 40 doctors have either completed the scheme or are currently undertaking it in different parts of the country. For most of them this has been an enriching opportunity.

There was a growing need perceived by many of them, to get together to share their experiences, reflect on the work undertaken and discuss issues arising out of this experience in the areas of hospital policy, medical education and the placement scheme itself. It was thought that such a group reflection and review would be a meaningful feedback to the organisers of the scheme, the faculty of the college and the members hospitals of the CHAI network. It would also be a starting point for collective action by this group that has been linked together by this common endeavour.

The matter was put to the CHAI and others informally and such a session was made possible by the CHAI invitation to these doctors to come together at SJMC on 19-20 May 1984.

B. OBJECTIVES :

The main objective of this first workshop was to give all these pioneers an opportunity to share their experiences and reflect together on all aspects of this scheme. The reflection would be introspective - to identify the key factors during the educational phase and later during the placement phase, which encouraged, supported and motivated these doctors in their commitment to the scheme. Conversely such reflection would also identify factors which hindered this process or acted as obstacles to it. It was hoped that from this reflection would emerge some critical and thought provoking feedback in many related areas, eg.,

a. Reorienting and strengthening the medical education process in SJMC to make it more relevant for future participants of the scheme;

b. Supportive and continuing education strategy for those who opt for the scheme and/or those who join peripheral hospital practice on a longer term basis;

c. Policy issues relevant to small hospital practice especially in the areas of patient care, drugs, investigations and staff;

d. Perspective for individual career decisions for the future.

C. WORKSHOP METHODOLOGY :

Only those doctors who had completed the scheme or had done atleast 6 months of it were invited for the workshop. 19 doctors out of 28 invited, attended this workshop. The sessions were planned on a group dynamic basis where the pariticipants themselves planned and facilitated the process and focus of discussions. Some alumni and staff were also invited to be present at this review.

The first day's programme consisted of an initial session of sharing of experiences followed by small-group discussions and a plenary session. On the second day the participants got an opportunity to meet and share their findings with the CHAI team and resource persons attending the CHAI Community Health Departments annual review meeting. This was followed by a meeting with the heads of departments of SJMC called by the Dean to consider this important feedback by the past students of the college (who had made it possible for the college to meet partially the objectives of the college).

D. RECOMMENDATIONS ON MEDICAL EDUCATION :

There has so far been no concerted effort to think of adapting or modifying the undergraduate training that students receive at SJMC to serve any special need since the RBS scheme itself took birth only three years ago and the number of graduates opting for it was quite small. However, with the increase in the penalty amount a situation will soon arise wherein the two year stint in a rural hospital will become an integral part of the course, like the compulsory rotating internship. With this change in trend, we feel strongly that the process leading to graduation should be so modified that at the end of our 5 1/2 years course, we are specifically equipped to work meaningfully in rural areas.

Drawing on the individual experiences of the pioneers and reinforced by a detailed discussion amongst us and a few alumni staff, the following points emerged with regard to the training we have received till the time we settled down to practice in the rural hospitals.

Studentship :

1. We are convinced that the process of training should begin with the entry of the student into the course. The rural orientation camp for the First MBBS students should be suitably planned in order to give them an early insight not only into an introduction to the aspects of rural life but also an introduction to the practice of medicine in rural areas. It would, therefore, be desirable to post them to work in the sub-centres under the SBI project at SJMC for a week or so during which they will actively assist the interns in their work (like helping with dressings, procedures and dispensing of medicines etc).

2. With the entry of students into their clinical postings, they should be entrusted with graded responsibilities in the actual management of hospital patients and should not remain mere spectators of the daily ward/OPD routine as at present. Irrespective of the departmnet to which they are posted they should be by rotation posted 'on duty' in the wards. During such postings they will be expected to stay in the ward for 24 hours with the teaching and house staff of the concerned units. Students on such duties could be exempt from lectures/ clinical classes/practicals with separate arrangements to have these and their tests fixed on non-duty days. In the wards they will be exposed to opportunities to master various nursing and medical procedures.

3. Schedule of graded responsibilities could be as follows during the clinical years

a. I Semester:

Maintaining daily vital signs record, diabetic urine chart, urine albumin chart, nephritic chart etc. Administering IM injections, simple dressings.

b. II Semester:

Passing Ryle's tube, giving enemas, Mouth and eye care, maintenance of intake/output record, monitoring of post-operative patients, special dressings, simple physiotherapy like active - passive exercises, ambulation of bed-ridden patients, assisting at medical and surgical procedures, assisting at normal deliveries etc., and compulsory casualty postings.

c. III Semester:

Giving IV injections, starting IV drips, drawing of blood for investigations, conducting deliveries, assisting at forceps extractions, assisting at minor surgery, recording EKG's, assisting at complicated dressings, therapeutic procedures like condys compresses, ECT's, out-patient surgical procedures.

d. IV Semester:

Assisting major surgical procedures, doing simple post-operative dressings, doing O.P. dressings, suture removals, assisting house staff in side-lab work, helping the CMO in casualty procedures, physiotherapeutic procedures like postural drainage, gait training etc., assisting at caesarian sections.

During this time students may also be sent to other/Government institutions for training in the fields of traumatology & truama management,

obstetrics etc where the availability of clinical material at St.John's would be found insufficient or inadequate.

e. V & VI Semester:

These 12 months shall be spent in completely equipping the student to independently function as a full-fledged doctor. In short he shall be carrying out all the functions interns are at present carrying out, except not being involved in decision making independently. During this period too, arrangements may be made in other institutions to have our students trained in fields where St. John's is yet to develop adequate potential.

Internship :

From the present situation in which internship is a period where skills are acquired there is a great need to utilize this period to promote the capacity for independent decision making. Proficiency in skills will be completed during the undergraduate clinical years as suggested above. Unlike the situation in a teaching institution where a battery of consultants affords a protective umbrella, the young doctor in a rural hospital has to take decisions on his own with no possibility to a 'second on call' being around to offer advice. So it is imperative that the intern not only learns to take decisions but also takes considered and correct decisions. This is possible only if there is a decentralisation of decision-making process in each department and unit. From the time bound, theoretical programme that it is now, a qualitative change should be effected in internship to make it a procedure and competence-based programme. This means that the professors will take the responsibilities of turning out a full fledged skilled and confident doctor at the end of internship. Some of the changes could be -

Medicine :

A greater emphasis should be laid on management of disorders by low cost rational drug therapy. An intern should also have done these procedures during his training - (a) endo tracheal intubations; (b) paracentesis; (c) lumbar puncture; (d) aspirations; (e) sternal punctures etc.,

Surgery :

Common procedures like (a) catherizations; (b) liver biopsy; (c) incisions and drainage; (d) excision biopsies; (e) herniorraphy; (f) hydrocele relieving procedures; (g) insertions of chest tubes; (h) plaster of paris - slab applications for fractures; (i) circumcision; (j) emergency side lab investigations and so on must be undertaken under supervision often enough to be skilled in attempting these in the future situation of the rural hospital.

OBG :

Skill in procedures such as (a) forceps extraction; (b) pudendal and other blocks; (c) breech extractions; (d) D & C; (e) instrumental evacuation; (f) caesarean section; (g) vacuum extractions; (h) suturing of perineal/vulval/cervical lacerations; (i) manual removal of placenta; (j) versions; (k) side lab investigations in emergencies must be ensured by supervised participation in situations when such procedures become necessary.

Community Medicine :

From the present posting of interns to sub-centres where their work is a passive general practice, a change should be made to posting interns (especially those who are definitely taking up the rural placement scheme) to work in hospitals under the scheme along with the graduates already working there. This will not only help them to develop relevant perspectives for such work but will also help them to identify areas where they should pay special attention during internship.

Other Postings :

1. Postings in Paediatrics, Orthopaedics, Opthalmology, ENT, Dermatology and Psychiatry should be compulsory - atleast 15 days each.

2. Electives in super-specialities should be given only as part of major postings for 15 days in the two months.

3. In casualty service the intern should be on first call.

Post-Internship :

When a graduate after internship feels he needs reinforcement in any particular area, he should be given an opportunity to work for 2-3 months more after internship during which period he would continue to get the same stipend as the interns and this period could be included in the period of rural service.

An interesting feature that emerged from the sharing of experiences was that all those who had participated in the scheme after completing 6 months - 1 year of senior housemanship fared better than those who went soon after internship. This is reflective of the lack of skill orientation in the present internship and the fact that in the present system, as such one has to be an SHO before one gets some opportunity for independent decision making.

Our recommendation is to make internship more skill oriented but in the event of their being practical difficulties in implementing such a recommendation the college should seriously consider allowing graduates to do a 6 month senior housemanship before sending them to run rural hospitals independently.

Refresher Courses :

Instead of a common refresher course every graduate working in a rural hospital should be given upto 1 month posting in a department/s of his choice during his service period in the hospital according to the convenience of the doctor and the hospital. This would be somewhat similar to the electives for the plantation medical officers that we hear the college offers at present.

Future Career Prospects :

1. Post Graduation in SJMC :

   i. For selection to PG courses in SJMC absolute preference should be given to SJMC graduates who have undertaken the RBS Scheme.

   ii. Extra weightage should be given to candidates

   - for every extra year of service done apart from the statutory two years
   - for persons who have worked in remote areas or areas of real need
   - for persons who have worked in TB/Leprosy hospitals
   - for persons who are willing to continue to work in rural areas after PG course. (He may be required to give another bond with the rural hospital or with SJMCH). If with the rural hospital, then they should sponsor him to the course.

2. Other Postgraduation Centres :

   CHAI can consider sponsoring him to other major teaching hospitals like CMC Vellore and Ludhiana, PGI Chandigarh for courses.

3. Jobs in Non-Scheme Hospitals :

   CHAI could arrange to find him a job in

   i. any other bigger member hospital after completion of two years on the scheme;

   ii. any other member hospital after completion of post-graduate courses. In effect CHAI would have to be actively involved with a career guidance and placement service, trying to link the availability of candidates to hospital situations which would best utilize the doctors' training/qualification and experience.

Newsletter :

i. This should be a monthly publication.

ii. Should reflect/review problems and needs of rural areas/rural hospital practice/rural hospital personnel.

iii. Should serve as a two way communication.

iv. Participants during the placement should share experiences, cases of interests and write articles of relevance to rural hospital practice.

v. Doctors who have completed placement should continue to write articles for the newsletter sharing their perspective with the newer participants on the scheme.

A FOLLOW UP PLAN

From the workshop itself including the discussions with a few college staff and CHAI team and resource personnel some ideas for follow up emerged.

1. A report documenting the main issues discussed and the suggestions/recommendations made should be prepared.

2. This report should be circulated for information/comment to

   i. all doctors on the rural placement scheme;

   ii. all departments of SJMC/H;

   iii. CHAI team and Executive Committee;

   iv. CBCI Society for Medical Education;

   v. all resource persons who could help with evolving follow up action.

3. A Committee was formed to take up the matters specifically related to medical education in St.John's and follow it up with the staff council and management. They would meet after the report is made to consider follow up action.

4. A meeting of the staff council of SJMC/H would also be held when two/three representatives of the participants would present the main findngs and suggestions directly to the staff.

5. The CHAI would initiate a process with SJMC management to set up the Liaison office which would follow up on all the recommendations on the rural placement scheme itself as well as the hospital policy issues. This would be taken up for discussion by introducing it as agenda for future meetings of member hospitals as well as by initiating a dialogue on these issues through the pages of Medical Service.

CONCLUSION

THE WORKSHOP hopefully was a beginning of a process. It is but relevant that graduates of a medical college committed to the objectives of producing professionals "dedicated in the service of the country and especially the disadvantaged and the poor', should come back after two years of service in rural areas to give a frank and constructive feedback to their teachers about the strengths and the weaknesses, the opportunities and threats they faced in their own medical training and in the rural placement scheme. This report marks the beginning of this process.

SOME ADDITIONAL NOTES

ISSUES OF CONCERN :

The review undertaken by the pioneers of the scheme over two days at SJMC resulted in a series of meaningful recommendations for improvement of the scheme and the preparatory training given by the college in the 5 1/2 years preceding it. Taking an overview of the entire discussion, the following emerge as important issues of concern which the CBCI, CHAI and SJMC should study seriously. In the months/years ahead suitable measures to tackle the problems should be evolved.

1. First and foremost is the growing commercialisation in the ethos and practice of hospitals in this network. This may be primarily related to the problems of funds required for making these hospitals self-supporting (especially in the absence of continuing external aid). In the light of the value system to which these institutions are committed in principle, this trend is particularly disquieting. This commercialisation is resulting in an increase in unethical practices in patient care, unnecessary investigations and hospitalisations, irrational and over prescribing of drugs and increasing inequalities in staff salaries and facilities. This trend is leading to an increasing option of care for the well-to-do and paying patient to the detriment of the large majority of the poor and needy patients. This trend is complicated further by a spirit of institutional competition.

2. The second important issue is the inadequacy of the training particularly of our medical/nursing colleges in the light of the growing needs and realities of the areas in which these peripheral institutions are situated. We are not training personnel to be specifically equipped to work effectively in small hospitals. Our training is highly specialised, technology oriented-based on curriculum that are geared to the needs of large Western type urban hospitals. The work in peripheral rural hospital require independent decision making, skill competency and a technically sound but innovative creativity which will help one to modify/adapt the management of the patient to the socio-economic and cultural realities of the people in the rural areas. Preparation for this is sorely lacking. The cultural ethos of most of our institutions kills rather than fosters the motivation/skills to work in areas of disadvantage.

3. The third important area is the lack of involvement of the doctors and the hospitals in the scheme in preventive/promotive rehabilitative or extension programmes in the community. In a few exceptions the doctors mentioned it in passing. Mainly these programmes, if and where they existed were responsibilities of nurses rather than doctors. The awareness that these programmes, wherever they may be initiated must move beyond distribution/welfare/charity programmes to awareness building/organisation/conscientization programmes where people participate in planning/decision making/organising programmes and see these as their rights, was singularly absent. This feature raises many questions about the rural orientation of the medical college teaching, the claims of the church institutions of the "preferential options for the poor" and the understanding of member hospitals and dispensaries in the very concept of health and their vocations.

4. The fourth important issue is the lack of sensitivity in our institutions and the professionals working in them including the young doctors to the social realities of inequality and injustice in the areas of work and even within the institutions. Most of the participants of the workshop were quite affected by the increasing commercialisation and the technical obsoleteness of the medical care in our hospitals which was a very positive sign that they were thinking and questioning. However, with few exceptions they were unaware of the problems of the people and even the para medical hospital staff. None of them mentioned the people as such in their sharing and the few that did had many negative and biased ideas based on a myopic professional understanding of the situation. This was both reflective of the lack of out reach programmes in most of the hospitals on the scheme thereby doctors having very little contact with the people. It was also probably reflective of the ethos of the training institution in which they had been formed. This lack of sensitivity to social realities seems to pervade SJMC and the leaders of the profession are so preoccupied with their own salaries and benefits and commitment to private practice that it may be an impossible task to expect them to transfer any other type of commitment to the students under training.

These four issues should become causes of concern since they question the relevance of health care and training provided under the umbrella of a church. We are convinced that through dialogue and a spirit of committed introspection, all concerned in CBCI, CHAI and SJMC will definitely identify means to tackle these issues and initiate processes to take church health services of the future in more relevant and people oriented directions.

Source: Edited version of a cyclostyled report circulated by CHAI/SJMC/CHC to all concerned. Recommendations on Rural Placement Scheme itself and some policy issues relevant to the hospitals selected for the scheme were also deliberated upon but have been left out from this version of this report which focusses only on 'Medical Education' issues.

APPENDIX II

MEMORANDUM ON 'A HEALTH UNIVERSITY 'TO GOVERNMENT OF KARNATAKA (1988)

To

The Chairman and
Members of the Committee for
University of Health Sciences in Karnataka.

Dear Sirs,

We the undersigned are a group of people interested and involved in Community Health Action and Research, who have come together recently to form a network to facilitate a greater collective dimension in our efforts, to enquire into the health problems and health priorities of the State and recommend policy alternatives and offer critical feedback to health policy makers and health team trainers in the State.

2. We encompass within our group, the disciplines of medicine, nursing, public health, social sciences, nutrition, management, social work, psychiatry, epidemiology, art, communications and journalism and related skills as well as derive our inspiration from years of grass roots field experience and involvement in health action through voluntary agencies and non-governmental community based organisations.

3. It is with this inter-disciplinary community oriented shared perspective and concern that we offer the following ideas and suggestions to you all, who have been requested by the Karnataka Government to examine and report on the setting up of a University of Health Sciences in Karnataka.

4. At the outset we welcome the Committee's initiative to seek the views of all those who are interested in this matter and appreciate the chance for a participatory dialogue.

5. We believe that the situation of education of the health team and particularly the medical education of the doctor has been severely compromised in the State in the recent decade by --

a. falling of standards in medical education caused by a dilution of requirements;

b. quantitative expansion at the cost of quality;

c. commercialisation of medical education by the growth of capitation fee oriented colleges;

d. generation of medical college growth on caste and religious affiliations;

e. phenomenal commercialisation of medicine and the health service structure; and

f. politicisation of academic bodies and the university ethos.

Therefore, we believe that not only is there an urgent need but a near crisis situation which the formation a University of Health Sciences may seek to redress, re-orient and realign toward our national and State priorities and stated goals of a secular, socialist democracy, and a society committed to rooting out injustice and inequity.

6. However, we believe that a unique project such as this should not just seek to halt the dilution of standards and provide a framework of standardisation but also seek to commit itself to certain long term goals of creative innovation along the goals suggested by three national bodies in recent years.

(a) Firstly, the Group on Medical Education and Support Manpower set up by the Government of India (Srivastava Report, 1975) has set before all medical educators the challenge that there is need

> "to design a system of education that is rooted in the scientific method and yet profoundly influenced by the local health problems and by the social, cultural and economic settings in which they arise"

and followed it up with a series of radical recommendations of great consequence.

(b) Secondly, the ICMR/ICSSR Health for All Study Group in 1981 has exhorted educators of health teams to prepare members for a

> "health care system which combines the best elements in the tradition and culture of the people with modern science and technology,
>
> - integrating promotive, preventive and curative functions,
> - democratic, decentralised and participatory,.
> - oriented to the people,
> - economical, and
> - firmly rooted in the community and aiming at involving the people in the provision of services they need.. and increasing their capacity to solve their own problem."

(c) Thirdly, the National Health Policy of 1982 categorically states that

> "the entire basis and approach towards medical and health education at all levels should be reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence who are professionally equipped and socially motivated to effectively deal with day to day problems within the existing constraints."

In line with these recommendations, we see a phenomenal opportunity for our State to pioneer and meet the challenges of producing more relevant health teams -- professionals and paramedics -- through the current move to set up a Health Sciences University.

7. We are particularly heartened at the use of the term 'Health Sciences' and not 'Medical Sciences', since we see that true to the comprehensive definition of health, the proposed University should seek to ultimately bring under its jurisdiction not only all the training institutions for doctors, nurses, pharmacists and para-medicals but also the training institutions of other systems of medicine so that through interactive dialogue, interdisciplinary teaching and an ethos of both respect and openness to the rich diversity of Indian inheritance, a truly National System of Health Team Education can be generated with great credit to our State.

8. We realise that the Committee cannot consider only lofty goals and long term visions but must start considering the project proposal in the context of the present realities and compulsions and state of medical education today. Hence, we present three sets of recommendations to the august committee:

I. Recommendations of improving medical education standards by bringing together all the 18 medical colleges and their teaching hospital under the jurisdiction of the University.

II. Recommendations of widening the scope and jurisdiction of the University by involving all other health training institutions of both allopathic and other systems of medicine.

III. Recommendations of radically altering the curriculum through initial experimentation and dialogue and pedagogical research from a long term point of view.

RECOMMENDATIONS

I. Recommendations to improve and standardise medical education in the State

WE RECOMMEND that all medical colleges in the State both private and government and their affiliated teaching hospitals be brought under the purview of the proposed University of Health Sciences with a view to --

(a) ensure that through regular inspection and dialogue, all the affiliated institutions follow the minimum requirements laid down by the Medical Council of India (MCI) and upgraded by the MCI from time to time. (MCI recommendations are minimum requirements and hence non-compliance with even minimum requirements is the first step to dilution of standards)

(b) ensure that no institution commercialises medical education by charging capitation fees in any form and through this commercial process caters predominantly to the needs outside the state, while at the same time pressuring the government for tax-payer subsidy through grant-in-aid and use of government hospitals.

(c) ensure that the policy of allowing medical colleges on caste/religion bias should be discontinued and all those existing under such auspices should be enabled to become more secular and cater to economically and socially disadvantaged through a quota system in which academic merit should be final within each quota.

(d) ensure that the existing MCI recommendations on social/rural orientation of medical education particularly --

i. rural and urban field practice areas;

ii. interdisciplinary community oriented teaching;

iii. community posting in pre-clinical/clinical years;

iv. referral services complex and affiliation of district hospitals and government primary health centres;

v. 6 months Community medicine posting in i 1/2 years compulsory rotating internship are implemented.

(e) ensure that the anamolous situations and disadvantage that is arising from the present policy of allotting meritorious government candidates in private and unrecognised colleges is prevented.

(f) ensure that all teachers of affiliated colleges are given the orientation courses recommended by the MCI:

i. Training in teaching methodology focussing on small group, interactivce, experiential and participatory methods;

ii. Social and community orientation and priorities for health services.

(g) ensure that the Social Sciences inputs into medical colleges particularly Preventive and Social Medicine Departments is strengthened.

(h) ensure that training in teaching methodology is introduced into all post-graduate courses.

(i) ensure that there is serious implementation of the ROME programme in which the total faculty of the medical college should be involved.

In addition, we believe that the Academic Council of the proposed University should from time to time keep tab on all the innovative ideas and methods of teaching that different institutions affiliated to the University generate and that all such ideas should be made known to other institutions to emulate.

The university, while standardising minimum standards, should encourage a certain degree of creative autonomy within the time and other constraints of the existing curriculum structure so that more relevant curriculum innovations can emerge to meet the overall goals of the University.

II. Recommendations to bring all Health Training Institutions under the University's Jurisdiction

WE RECOMMEND that

(a) the University should bring under its jurisdiction in a phased manner all training institutions in the State, at all levels of health service so that an integrated and coordinated approach to health manpower development can emerge. These institutions would include:

i. Nursing, Dental, Pharmacy colleges

ii. Rural Health & Family Planning Training Centres and ANM training schools

iii. Colleges of Indian and other non-allopathic systems of Medicine

(b) The Academic Council and Syndicate of the University should have in its membership senior educators from all these groups of colleges to enhance the integrated effort.

(c) In the process of delinking health training institutions from the general universities, care should be taken that various other university disciplines like the Behavioural Sciences, Management, Social Work and so on are represented on the Academic Council of the proposed University -- this being ensured by members of such departments invited to participate in the deliberations of the Council.

(d) As a first step towards greater dialogue and acceptance of the role and contribution of each member of the team and the different systems of medicine, a plan of short orientation and 'bridge' course should be evolved and introduced into the curriculum of all courses; eg., The doctors should be given basic orientation in nursing, other systems of medicine and vice-versa.

(e) At a later stage, a series of optional and elective courses should be built into the Health University system to enable any member of health team to supplement his knowledge and skills by taking additional short certificate courses.

(f) At a final stage, para-medical and professional training must be so linked up in a career ladder pattern so that some experienced para-medicals should be able to opt for and be supported through professional courses.

III. Recommendations to radically alter the curriculum through experimentation and dialogue and pedagogical research.

There has already been a lot of thinking and brainstorming on the need and some of the content of radical reform of medical education. The Srivastava Report warns that :

> "no uesful purpose would be served by continuing an endless debate on the content of these reforms. What is needed most is the creation of a suitable structure, with adequate administrative machinery and funds at its disposal, and to charge it with the responsibility of determining and implementing a radical programme of reform in medical and health education in the years ahead."

We believe that all the above recommendations are possible given the political will and the administrative/financial and technical safeguards built into the University of Health Sciences Bill.

Research Commission :

However, radical reform needs research and exploration into many other aspects of the existing system, which have only received lip sympathy till now.

WE RECOMMEND that

the Academic Council and Syndicate should constitute an interdisciplinary educational research commission which looks into each of these issues from a futuristic basis and makes suitable recommendations to the Academic Council of the proposed University after dialogue with MCI so that each of these issues is considered and added to the re-orienting process of existing efforts. These areas include --

i. Research into teaching methods and examination/ evaluation methods;

ii. Gender bias in content of curriculum;

iii. Teaching in the vernacular medium;

iv. Conceptual and organisational framework for the evolution of a National System of Medicine;

v. Link of educational effort with manpower needs and career planning of existing manpower;

vi. Role of Non-Governmental Organisations, General Practitioners and unaffiliated small peripheral institutions in training programmes.

9. We believe that the role of the Directorate of Medical Education needs to be continued only if the Committee believes that the Academic Council and Syndicate of the propsed University cannot handle all the functions that is presently carried out by the Directorate. Except for the liaison of the institutions affiliated to the propsed University with the rest of the health services we believe that most other functions can be taken over. The Directorate, if continued, will have more of a liaison rather than a directive role and in that sense will have a more limited function. In either case efforts must be made to depoliticise this appointment and ensure that a holistic vision and commitment to the goals of the University is given priority over seniority and political compulsions.

This is actually even more true for all the appointments to the proposed university structure.

10. With reference to the fifth term of reference given to the Committee, we believe that the University should bring the colleges and main hospitals affiliated to the institutions under its jurisdiction as well as all the research institutions. For district hospitals, primary health centres and urban health centres that are affiliated to present teaching institutions, a more flexible policy may have to be evolved since to avoid a region, a district, a primary health centre or a specific centre, getting all the attention and support from training institutions, it may be necessary to rotate the affiliation over a period of time so that all district hospitals, taluk level hospitals and primary health centres are affiliated at some time of the other thereby improving the quality of service and training and continuing education of the centre/hospital staff.

11. Finally we believe that if the Committee recommends the setting up of a University of Health Sciences after examining all the related, incidental and ancillary issues connected with the proposal, a larger dialogue should be initiated with all those concerned about improving, re-orienting or making more relevant the present pattern of health team training and professional education in the State.

Our network would be willing to support this dialogue and any such forum set up by the Committee, and do more home work and provide more comprehensive and detailed recommendations on the ideas and views suggested in this memorandum.

12. While thanking the Committee for this opportunity to share our collective ideas about the proposed University, we sincerely hope that the much needed radical reform that has been much talked about in the country and in this State in the past, now finds serious consideration, imaginative leadership and sustained encouragement through your efforts.

Sub-Committee on Recommendations for University of Health Sciences, Karnataka.

for COMMUNITY HEALTH NETWORK (KARNATAKA)

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APPENDIX III

- Pros and Cons for an 'Alternative Medical College'

Three Crucial Questions

A. What is the need to start a new medical college/institution for this purpose?

For

1. Most insitutions who are now interested in re-orienting Medical Education did not do adequate homework in planning the new strategy and so have ended up with 'pious' claim in the prospectus or at the most a few years of experimentation followed by a status quo.

2. The experimentation has been somewhat 'ad-hoc' and often in some disciplines only. The whole medical college faculty as a team or even a core multi-disciplinary team have usually not been involved. The overall content and value system is mostly of the established system.

3. The older institutions have developed an inertia, resisting innovation either due to weaknesses in the early experiments itself, peer group pressure, established values and focus of the existing system, or the social values of teachers and students and parents and the governing board.

4. Most of the experimentation has been on evolution of some new programmes; follow up of good ideas of some faculty; transplanting ideas tried out elsewhere in other institutions sometimes out of context and so on. A detailed exercise of identifying needs, setting objectives, evolving teaching content and methodology as a complete process has not been done.

5. The new Medical College needs to evolve a new institutional ethos and a critical faculty to relook at established values, methodologies, concepts and so on. This tradition can be built up as a new venture. Changing these in an established college which has shown 'excellence' or 'promise' in the established transplanted system is difficult.

6. 'Success' in the present paradigm of Medicine may itself be a 'barrier' to exploration of an alternative paradigm.

7. All the existing medical colleges, even those who have tried out some experiments have not questioned the basic underlying philosophy and logic of the present 'westernised' system. Some of the good innovations/changes made have essentially been by

individual/small groups, but have never been accepted or internalised by the system which sees all these as of great threat to their orthodox styles of functioning. Perhaps it would be necessary to have a new and open environment, to dare to be self-critical and change appropriately.

Against

1. It is operationally easier, cost-effective and sensible to incorporate these ideas into an existing institution provided

   a. a climate for innovation and change can be built up,

   b. a commitment to relate to social need is ensured (because there are many innovations unrelated to social need).

2. It will be more acceptable to all concerned when established institutions change tracks with changing circumstances rather than if the institution is completely new, lacks established credibility and as a result can get marginalised and ignored. It will also prove that existing institutions can and do change which ultimately will be necessary for there to be a major impact in training doctors for India's social needs. A de novo college can always be viewed as an experiment with unusual factors and hence not replicable.

3. If the alternative curriculum is a response to a deeper understanding of social needs and the social milieu, then there is no reason why an existing team of a college cannot support the alternative as long as they get a deep and thorough orientation to the evolving concepts and process.

4. Those who have experienced and participated in the present track know its pitfalls, limitations and difficulties if they have been serious in their endeavour. They are more likely to appreciate and sustain a gradually evolving alternative process than a set of 'idealists' who evolve an ideal curriculum on paper but do not have the experience to sustain or operationalise it.

5. India already has a surfeit of medical colleges, many of which were started with social objectives as well. Adding one more may be unnecessary.

B. Why should that be in the Voluntary/NGO/Mission sector ?

(Voluntary/Mission sectors are not synonymous. A secular effort initiated by 'Missions' may prove more fruitful)

For

1. There is possibility of greater adaptability and flexibility to changing circumstances as compared to the government sector.

2. Minority insitutions committed to a 'value system' especially the 'Mission sector' have shown a continued commitment of purpose and responsiveness which supports innovation and excellence.

3. Minority Right provides greater flexibility for student and staff selection which could become crucial components of an alternative experiment atleast at the experimental stage.

4. The alternative curriculum derives sustenance from a social commitment and vision of the alternative team. This is more likely to be sustained in a voluntary and or Mission sector since such congruence between social vision of the endeavour and the faith and mission values of the insitutions are possible. The group could take positive steps to actively interact with the mainstream through participation in professional associations/exchange programmes and networks.

Against

1. The Government sector may not take it seriously and so may not be affected by it. There is a tendency for Minority institutions to be marginalised by the establishment especially if they push the minority label too much.

2. Minority institutions themselves have tended to stay aloof from interaction/confronting the government system. They often fail to fit into mainstream requirements and are prone to getting walled off from national influence many of which can also be positive stimulus for developing into appropriate centres for education. e.g., it is not unusual for Mission institutions to see their graduates as being destined to work in Mission hospitals and not as leaven in the general governmental medical system.

3. The so called voluntary / Mission sector is today being fast overtaken by the Private Corporate sector as well as being forced to change value systems due to the 'market forces'. So that the label is not a sufficient pre-condition for serious innovation.

C. Should the Effort be to Produce :

(a) an 'appropriate' medical graduate?

(b) to take the present medical graduates and give them 'appropriate' PG training?

for (a)

1. Most of the existing graduates are not socially oriented or 'professionally competent' to work in Primary Health Care of Community Practice. There is need to change the system to produce appropriate graduates from all the existing institutions even if the start is with a few.

2. The existing system has been critically analysed and found to 'block' the development of certain skills that are required in the Primary Health Care situation, so change in graduate education is inevitable.

3. Certain fundamental attitudes and principles of problem based learning, self learning, field based learning etc., would enhance the existing skill of medical college products even if they predominantly choose as at present, secondary and tertiary care centres as career options. The appropriate transformation of graduate training is therefore inevitable.

for (b)

1. Many of the doctors graduating from the existing colleges are 'misfits' as far as national needs and priorities. They can only land up in the growing urban private profit-oriented sector. If 'Health for All' has to be a reality than many need retraining/continuing education to refit them towards newer job opportunities. An IAS type orientation training post-selection for government doctors and pre posting is crucial. This could be at two levels:

   I. All doctors selected by UPSC and State Boards should be given a reorientation course, which is substantial in skill / knowledge but not necessarily a PG level course.

   II. All PHC based doctors could get an inservice continuing education through distance learning modules as well as regular contact seminar leading to a PG qualification. With the era of open university being established in India, this needs to be explored actively.

III. Revamping existing DPH and MD (PSM) training is an equally crucial task.

This question is not really an either or alternative. Any alternative experiment whether in an existing or a new institution should simultaneously promote exploration / experiment at both levels. The problems encountered by PG training of existing graduates would cross fertilize the evolution of the graduate training itself ! Appropriate PG training would help in tiding over the existing crisis of a 'glut' of 'Misfits' and also advance the knowledge inputs required for innovation at other levels

All those interested in launching an alternative experiment are requested to reflect on the above 'pros' and 'cons' collectively and make their own group/institutional decision.